OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay the authorization process**.

Drug Requested: **Chronic GI Motility Drugs**

DRUG INFORMATION: Check box(es) that apply or authorization process will be delayed.

Preferred Medication must be tried and failed 1st	Non-Preferred Medications
❑ Amitiza® **OR** ❑ Linzess® **OR** ❑ Movantik®	❑ Lotronex® ❑ Relistor® ❑ Trulance™ ❑ Viberzi™ ❑ Symproic®

Drug Name/Form/Strength: _____

Dosing Frequency: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

DIAGNOSIS AND MEDICAL INFORMATION: **ALL** information **MUST** be checked to qualify.

Does the patient have any of the following diagnoses? **Please check ALL that apply.**

- Idiopathic Chronic Constipation (ICC) ❑ Yes ❑ No
- Constipation Predominant Irritable Bowel Syndrome (IBS-C) ❑ Yes ❑ No
- Severe Diarrhea Predominant Irritable Bowel Syndrome (IBS-D) ❑ Yes ❑ No
- Opioid Induced Constipation in chronic NON-cancer pain (OIC) ❑ Yes ❑ No
- Other: _____ ❑ Yes ❑ No

1) Amitiza® / Linzess® / Trulance™: Has the patient had a treatment failure on at least **TWO *(2)*** of the following classes? ❑ Yes ❑ No

Osmotic Laxatives (i.e., lactulose, polyethylene glycol, sorbitol), **Bulk forming Laxatives** (i.e. psyllium, fiber) **OR Stimulant Laxatives** (i.e. bisacodyl, senna)? ❑ Yes ❑ No

2) Amitiza® / Movantik®/ Symproic® **(OIC only):** Has the patient had treatment failure on both polyethylene glycol **AND lactulose?** ❑ Yes ❑ No

3) Lotronex® / Viberzi™: Has the patient had a treatment **failure on at least THREE (3) of the following classes?**

Bulk forming Laxatives (i.e. psyllium, fiber), **Antispasmodic Agents** (i.e. dicyclomine, hyoscyamine) **OR Antidiarrheal Agents** (i.e. loperamide, diphenoxylate/atropine, codeine)? ❑ Yes ❑ No

(continued on next page)

List pharmaceutical agents attempted and outcome:

1. _____

2. _____

MEDICAL NECESSITY: Provide clinical evidence that the Preferred drugs will NOT provide adequate benefit.

_____

_____

_____

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Member Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~6/30/2017; 8/28/2017; 12/31/2017; 7/1/2018;~~ **8/17/2018**