

**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 authorization process.**

Drug Requested: Egrifta™ (tesamorelin)

DRUG INFORMATION: Complete information below or authorization process will be delayed

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

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

- **Recommend dose:** 2 mg injected subcutaneously once daily.

CLINICAL CRITERIA: Box **MUST** be checked to qualify. Incomplete information will delay authorization process.

- Patient is HIV-positive with lipodystrophy.

Medication being provided by (check applicable box below):

- Physician's office **OR** Specialty Pharmacy - PropriumRx

****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 #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____