

**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 1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete forms will delay the authorization process.**

**Drug Requested:** Elelyso® (taliglucerase alfa) (Injection for IV use) **(Medical)**

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

**Drug Form/Strength/Quantity per Day:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_ **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code, if applicable:** \_\_\_\_\_

**CLINICAL CRITERIA:** To receive a **one year approval** for this drug, **ALL** appropriate boxes below **must** be checked to qualify or authorization process will be delayed.

**Does member meet the following criteria?**

- Is member using this for long-term enzyme replacement therapy with a confirmed diagnosis of Type 1 Gaucher disease?  Yes  No
- Is member 18 years of age or older?  Yes  No

**Medication being provided by:** (Please 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 #:** \_\_\_\_\_