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**

PREFERRED Medication (One of the following MUST be tried and failed first)		
❑ Amitiza®	❑ Linzess®	❑ Movantik®
Non-Preferred Medications		
❑ Lotronex®	❑ Relistor®	❑ Trulance™
❑ Viberzi™	❑ Symproic®	❑ alosetron

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

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.**

- ❑ Chronic Idiopathic Constipation (CIC)
- ❑ Constipation Predominant Irritable Bowel Syndrome (IBS-C)
- ❑ Severe Diarrhea Predominant Irritable Bowel Syndrome (IBS-D)
- ❑ Opioid Induced Constipation in chronic NON-cancer pain (OIC)
- ❑ Other: ____

For 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

For Amitiza® / Movantik®/ Relistor® / Symproic® (OIC only):

Has the patient had treatment failure on both polyethylene glycol **AND** lactulose? ❑ Yes ❑ No

(continued on next page)

For alosetron / Lotronex® / Viberzi™:

Has the patient had a treatment **failure on at least THREE (3) of the following classes?** ❑ Yes ❑ No

- Bulk forming Laxatives (i.e. psyllium, fiber),
- Antispasmodic Agents (i.e. dicyclomine, hyoscyamine) **OR**
- Antidiarrheal Agents (i.e. loperamide, diphenoxylate/atropine, codeine)?

List pharmaceutical agents attempted and outcome:

1. ______________________________
2. ______________________________
3. ______________________________

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

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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;~~ **11/3/2018**