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: Juluca™ (dolutegravir and rilpivirine)

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

Drug Form/Strength: _____

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

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

Recommended dosage: 1 tablet once daily with a meal. **Quantity Limit:** 30 tablets/30 days

CLINICAL CRITERIA: To receive a **ONE (1) year approval** for this drug, the following questions **MUST** be checked to ensure authorization process will **NOT** be delayed.

1. Does member have a diagnosis of HIV? ❑ Yes ❑ No
2. Is member ≥ 18 years of age? ❑ Yes ❑ No
3. Is member currently taking dofetilide, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifapentine, dexamethasone, St. John's Wort, or proton pump inhibitors? ❑ Yes ❑ No
4. Is member on any other antiretroviral treatment (ART)? ❑ Yes ❑ No
5. Does member have resistance or treatment failure to other HIV agents? ❑ Yes ❑ No
6. Is member ART-naïve? ❑ Yes ❑ No
7. Has member achieved virologic suppression (HIV-1 RNA < 50 copies/mL) for at least 6 months on their current ART regimen? ❑ Yes ❑ No
8. If female, is member breast feeding? ❑ Yes ❑ No

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 #: _____

REVISED/UPDATED: ~~7/1/2018;~~ **8/23/2018**