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 forms will delay the authorization process**.

Drug Requested: (Please check applicable drug below)	
❑ **Juxtapid**® (lomitapide) capsules	❑ **Kynamro**® (mipomersen sodium) Inj

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

Dosage Name/Form/Strength: _____

Quantity per Day: _____ **Length of Therapy:** _____

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

CLINICAL CRITERIA: Check applicable box (es) below to ensure authorization will **NOT** be delayed.

- Does the patient have a diagnosis of homozygous familial hypercholesterolemia (HoFH)? ❑ Yes ❑ No
- Is the patient at least 18 years of age? ❑ Yes ❑ No
- Is the prescribing provider certified with the applicable REMS program? ❑ Yes ❑ No
- Has the patient had a treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents and bile acid sequestrants? ❑ Yes ❑ No
- List previous medications (include drug name/dose): _____

_____

_____

_____

***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: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~6/29/2017; 8/31/2017;~~ **8/23/2018**