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: Mytesi™ (crofelemer) **(formerly Fulyzaq®)**

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

Drug Name/Form/Strength: _____

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

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

Quantity per Day: _____

CLINICAL CRITERIA: To receive a **THREE (3) month approval**, boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

- Is member 18 years of age or older? ❑ Yes ❑ No
- Does member have diagnosis of HIV/AIDS? ❑ Yes ❑ No
- Is member currently on anti-retroviral therapy? ❑ Yes ❑ No
- What antidiarrheal(s), if any, has member tried? Please list names:
  _____
  _____
- Has infectious diarrhea been ruled out? ❑ Yes ❑ No
- Does member have any other GI conditions or medications that can cause diarrhea? ❑ 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: ~~12/23/2017;~~ **8/27/2018**