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: Palynziq™ (pegvaliase-pqpz)

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

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: To receive approval for this drug, all information below **must** be checked to qualify or authorization process will be delayed.

Initial Approval – 16 weeks

1. Does member have a diagnosis of phenylketonuria with uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management? ❑ Yes ❑ No

AND

2. Is the member 18 years or older? ❑ Yes ❑ No

AND

3. Must obtain baseline blood phenylalanine concentration before initiating treatment. Is the blood phenylalanine concentration greater than 600 micromol/L? ❑ Yes ❑ No

AND

4. Will administer the initial dose under the supervision of a healthcare provider and train the member and/or caregiver on proper self-administration for future administration? ❑ Yes ❑ No

AND

5. Palynziq™ is available only through a restricted program under a REMS called the Palynziq™ REMS. Is the prescriber certified with the Palynziq™ REMS program? ❑ Yes ❑ No

AND

6. Is member enrolled in the Palynziq™ REMS program and educated on the risks of anaphylaxis? ❑ Yes ❑ No

AND

7. Member MUST have a prescription for auto-injectable epinephrine. ❑ Yes ❑ No

AND

(continued on next page)

RENEWALS: Approve for one (1) year if member maintains blood phenylalanine concentration reductions of 20% below baseline measurements.

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: 10/27/2018**