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: SymLin® /SymLinPen® (pramlintide acetate) **(Non-Preferred)**

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:** ______________________

CLINICAL CRITERIA: **ALL** boxes **must** be checked to qualify to ensure authorization process will **NOT** be delayed.

- ❑ Patient is meeting **ALL** of the following criteria **(and may be approved)**:
  - ❑ Diagnosis of Type 1- or 2- diabetes

    AND
  - ❑ On insulin therapy

    AND
  - ❑ Failure to achieve adequate glycemic control (HbA1c > 6.6%)
- ❑ Patient must have a history of at least a 90-day trial of insulin

*****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: 6/30/2017; 9/1/2017; 6/17/2018; **8/30/2018**