

**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: Triumeq® (abacavir/dolutegravir/lamivudine)

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

Drug Form/Strength/Quantity per Day: _____

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

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

CLINICAL CRITERIA: To receive a **ONE (1) year approval** for this drug, **ALL** appropriate boxes below **must** be checked to qualify to ensure authorization will **NOT** be delayed.

Does member meet the following criteria?

- Is member 18 years of age or older? Yes No
- Screening results for HLA-B 5701 allele:
 - HLA-B 5701 allele absent? Yes No

NOTE: Triumeq® is **contraindicated** in patients who are positive for this allele

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request.

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 #: _____