OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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: ***Oral Hypoglycemics with Metformin Step Edit (MEDICAID)***

Applicable box(es) below MUST be checked to qualify:

PREFERRED	Non-Preferred
Alpha-Glucosidase Inhibitors	
❑ Acarbose	❑ Glyset ❑ Miglitol (generic Glyset) ❑ Precose
DPP-IV Inhibitors and Combination	
❑ Janumet ❑ Janumet XR ❑ Januvia ❑ Jentadueto ❑ Tradjenta	❑ Alogliptin (generic Nesina) ❑ Alogliptin/pioglitazone (generic Oseni) ❑ Alogliptin/metformin (generic Kazano) ❑ Jentadueto XR ❑ Kazano ❑ Kombliglyze XR ❑ Nesina ❑ Onglyza ❑ Oseni
Meglitinides	
❑ Repaglinide ❑ Nateglinide	❑ Prandin ❑ PrandiMet ❑ Repaglinide/metformin ❑ Starlix
Second Generation Sulfonylureas	
❑ Glimepiride ❑ Glipizide ❑ Glipizide ER ❑ Glyburide ❑ Glyburide micronized	❑ Amaryl ❑ Diabeta ❑ Glucotrol ❑ Glucotrol XL ❑ Glynase
Thiazolidinediones	
❑ Pioglitazone	❑ Avandia ❑ Actoplus Metformin IR & XR ❑ Actos ❑ Avandaryl ❑ Avandamet ❑ Duetact ❑ Pioglitazone/metformin ❑ Pioglitazone/glimepiride

Drug Information: ***Complete information below to qualify or authorization process will be delayed.***

Drug Name/Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy**: ______________

Diagnosis: ______________________ ***ICD Code, if applicable***: ______________

(continued on next page)

Clinical/Step-Edit Criteria for ALL Preferred and Non-Preferred Oral Hypoglycemics. Boxes must be checked to qualify or authorization process will be delayed.

- ❑ Patient is a newly diagnosed Type II Diabetic: ❑ **Yes** **OR** ❑ **No**

AND

If ***NO***, has the patient tried and failed at least ***90 days of therapy*** with metformin unless contraindicated?
❑ **Yes** **OR** ❑ **No**

OR

If ***YES*** the following criteria must be met: Please complete the following information to qualify:

- ❑ **HgbA1c:** ______________________ **AND** **Date** ______________________________

❑ Patient has a Hemoglobin A1c <9%	❑ Patient has a Hemoglobin A1C $\geq$ 9%
❑ Patient has tried and failed at least 90 days of therapy with metformin unless contraindicated*	❑ Patient is on metformin unless contraindicated* plus a second agent (e.g., DPP-IV, SGLT2, GLP-1 receptor agonists, TZDs, sulfonylureas)

Contraindications include:

- ❑ Severe renal impairment (eGFR below 30ml/min/1.73m2)
- ❑ Known hypersensitivity
- ❑ Acute or chronic metabolic acidosis including diabetic ketoacidosis

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: ~~6/11/2018;~~ **7/16/2018**