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: Symfi Lo™ (efavirenz, lamivudine and tenofovir disoproxil fumarate) ***(MEDICAID)***

DRUG INFORMATON: 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. Authorization approval: 1 year.

1) Does member have a diagnosis of HIV? ❑ Yes ❑ No

AND

2) Does member weigh ≥ 35 kg? ❑ Yes ❑ No

AND

3) Member will be tested for hepatitis B infection prior to initiation of therapy. ❑ Yes ❑ No

AND

4) Does member have a creatinine clearance (CrCl) ≥ 50 mL/min within the last 30 days? ❑ Yes ❑ No

AND

5) Member does ***NOT*** have moderate to severe hepatic impairment (Child Pugh B or C). ❑ Yes ❑ No

AND

6) Member is ***NOT*** on other antiretroviral treatment (ART) medications. ❑ Yes ❑ No

AND

7) Member is ***NOT*** on concurrent elbasvir and/or grazoprevir. ❑ 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: 7/1/2018