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 the authorization process.***

Drug Requested: ***Chronic GI Motility Drugs*** **MEDICAID**

DRUG INFORMATION

Preferred Medication must be tried and failed 1st	**Non-Preferred Medications**
Amitiza® (lubiprostone), **OR Linzess®** (linaclotide) **OR** ❑ **Movantik®**	❑ Lotronex® ❑ Relistor® ❑ Trulance™ ❑ Viberzi™

Drug Name/Form: _____ **Strength**: _____

Dosing Frequency: _____ **Length of Therapy**: _____

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

DIAGNOSIS AND MEDICAL INFORMATION

Does the patient have any of the following diagnoses? **Please check *ALL* that apply.**

- Idiopathic Chronic Constipation (ICC) ❑ Yes ❑ No
- Constipation Predominant Irritable Bowel Syndrome (IBS-C) ❑ Yes ❑ No
- Severe Diarrhea Predominant Irritable Bowel Syndrome (IBS-D) ❑ Yes ❑ No
- Opioid Induced Constipation in chronic NON-cancer pain (OIC) ❑ Yes ❑ No
- Other: _____ ❑ Yes ❑ No

1) Amitiza® / Linzess® / Trulance™: Has the patient had a treatment failure on at least **TWO *(2)*** of the following classes? ❑ Yes ❑ No

Osmotic Laxatives (i.e., lactulose, polyethylene glycol, sorbitol), **Bulk forming Laxatives** (i.e. psyllium, fiber) **OR** **Stimulant Laxatives** (i.e. bisacodyl, senna)? ❑ Yes ❑ No

2) Amitiza® / Movantik® **(OIC only):** Has the patient had treatment failure on both polyethylene glycol **AND lactulose?** ❑ Yes ❑ No

3) Lotronex® / Viberzi™: Has the patient had a treatment **failure on at least THREE (3) of the following classes?**

Bulk forming Laxatives (i.e. psyllium, fiber), **Antispasmodic Agents** (i.e. dicyclomine, hyoscyamine) **OR** **Antidiarrheal Agents** (i.e. loperamide, diphenoxylate/atropine, codeine)? ❑ Yes ❑ No

List pharmaceutical agents attempted and outcome:

1. _____

2. _____

MEDICAL NECESSITY: Provide clinical evidence that the **Preferred** agent(s) will not provide adequate benefit.

_____

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 #: _____ Member Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~6/30/2017; 8/28/2017;~~ **12/31/2017**