# 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 forms will delay the authorization process.***

**Drug Requested: Cerdelga™** (eliglustat) capsules

***DRUG INFORMATION:*** ***Complete information below. If incomplete, authorization process 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 or authorization process will be delayed.***

- **Does member meet the following criteria?**
  - Is member 18 years of age or older? ❑ Yes ❑ No
  - Diagnosis of Gaucher disease type 1 ❑ Yes ❑ No
  - An FDA-cleared test for determining CYP2D6 genotype has been performed? ❑ Yes ❑ No
    - Indicate genotype test results:
      - Extensive metabolizer (EM)? ❑ Yes ❑ No
      - Intermediate metabolizer (IM)? ❑ Yes ❑ No
      - Poor metabolizer (PM)? ❑ Yes ❑ No
      - Ultra-rapid metabolizer? ***(Cerdelga use not recommended)*** ❑ Yes ❑ No
      - Indeterminate metabolizer? ***Cerdelga use not recommended)*** ❑ Yes ❑ No

***MEDICAL NECESSITY*: *Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request. If not completed, authorization process will be delayed.***

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*****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: 12/23/2017**