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: Mytesi™ (crofelemer) ***(formerly Fulyzaq®)***

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

Drug Name/Form/Strength: _____

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

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

Quantity per Day: _____

CLINICAL CRITERIA: To receive a THREE (3) month approval, boxes MUST be checked to qualify or authorization process will be delayed.

- Is member 18 years of age or older? ❑ Yes ❑ No
- Does member have diagnosis of HIV/AIDS? ❑ Yes ❑ No
- Is member currently on anti-retroviral therapy? ❑ Yes ❑ No
- What antidiarrheal(s), if any, has member tried? Please list names:

  _____

  _____
- Has infectious diarrhea been ruled out? ❑ Yes ❑ No
- Does member have any other GI conditions or medications that can cause diarrhea? ❑ 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: 12/23/2017