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: **Saxenda®** (liraglutide)

This is a group specific benefit.

DRUG INFORMATION: ***Complete information below. Authorization process will be delayed if incomplete.***

Drug Name/Form/Strength: _____

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

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

******LENGTH OF AUTHORIZATION IS 16 WEEKS ONLY******

Continued approval is contingent upon patient continuing to lose/maintain weight up to the desired BMI

- **Pregnancy Category X**

CLINICAL CRITERIA*: *Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed. Chart /progress notes MUST be attached to this request.

❑	Height: _____ Weight:_____ Date measured:_____
❑ ❑	Patient has a BMI of 40 or greater **OR** Patient has a BMI of 35 with co-morbid condition(s): _____ (may include coronary artery disease, hypertension, CHF, diabetes, dyslipidemia, or sleep apnea.) ***Please note: if medication claims documenting the co-morbid condition(s) are not present, chart notes may be requested***
❑	Trial and failure of at least ***one full course (defined below) of TWO (2)*** of the following: ❑ **Adipex-P®** (phentermine HCl)- 16 weeks ❑ **Suprenza®** (phentermine HCl)- 16 weeks ❑ **Contrave®** (naltrexone HCl/bupropion HCL)- 12 weeks ❑ **Belviq®** (lorcaserin)- 12 weeks ❑ **Xenical®** (orlistat)- 16 weeks ❑ **Qsymia®** (phentermine/topiramate ER)- 16 weeks ***NOTE: if a full course of medication could NOT be achieved due to intolerance/adverse event, submit documentation (chart/progress notes).***

*****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: 8/27/2017**