OPTIMA HEALTH PLAN

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 1-800-750-9692. 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 (*select one*):

❑ **Kombiglyze™ XR** (metformin extended- release and saxagliptin)	❑ **Kazano®** (metformin and alogliptin)

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***: _____

CLINICAL CRITERIA*: *Boxes below must be met to qualify or authorization process will be delayed.

❑ Patient has tried and failed therapy with Janumet® **or** Janumet XR®

AND

❑ Patient has tried and failed therapy with Jentadueto®

*****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 #: _____

*** Approved by the Pharmacy and Therapeutics Committee:** 10/15/2009
REVISED/UPDATED: ~~6/10/20115/17/2012; 10/22/2012; 3/21/2013; 6/18/2013; 3/20/2014; 11/2/2014; 5/22/2015; 12/28/2015; 12/19/2016;~~ **9/21/2017**