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: **Oseni®** (alogliptin and pioglitazone)

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

Drug Form/Strength: ______________________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________________

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

CLINICAL CRITERIA: The criteria below must be met to qualify or authorization process will be delayed.

- ❑ Patient has tried and failed therapy with Januvia®

AND

- ❑ Patient has tried and failed therapy with Tradjenta®

AND

- ❑ Patient has tried and failed therapy with pioglitazone

*****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:** 3/21/2013
REVISED/UPDATED: 6/18/2013; 4/10/2014; 11/2/2014; 5/22/2015; 12/29/2015; 12/19/2016; **9/22/2017**