

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: Soliqua® (insulin glargine and lixisenatide injection) **Commercial Only**

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: _____

CLINICAL CRITERIA: Check below that applies. If not checked, authorization process will be delayed.

Patient has tried and failed at least **30 days** of therapy with **one** of the following:

<input type="checkbox"/> Byetta®	<input type="checkbox"/> Trulicity®
<input type="checkbox"/> Bydureon®	<input type="checkbox"/> Victoza®
<input type="checkbox"/> Lantus®	<input type="checkbox"/> Toujeo®

****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: 7/20/2017
REVISED/UPDATED: 9/14/2017