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: **Adlyxin™** (lixisenatide injection 20 mcg) **(COMMERCIAL ONLY)**

DRUG INFORMATION: Complete all information below or authorization will be delayed.

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: **ALL** boxes **must** be checked to qualify or authorization will be delayed. Chart notes **MUST** be attached to this request.

- ❑ Patient has tried and failed at least **30 days** of therapy with **two (2)** of the following:

❑ Byetta®	❑ Victoza®	❑ Ozempic®
❑ Bydureon®	❑ Trulicity®	

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:** ~~7/19/2012~~; 2/22/2017
REVISED/UPDATED: ~~9/28/2012; 7/17/2014; 7/22/2014; 9/26/2014; 10/7/2014; 10/8/2014; 11/5/2014; 3/19/2015; 4/29/2015; 5/27/2015; 12/29/2015; 12/20/2016; 2/22/2017; 3/20/2017; 8/18/2017; 9/14/2017; 6/25/2018;~~ **1/28/2019**;