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 ***(please check applicable box below)*****:** ***(COMMERCIAL ONLY)***

❑ **Adlyxin™** (lixisenatide injection 20 mcg)	❑ **Ozempic®** (semaglutide injection 0.5mg/1mg)

DRUG INFORMATION: ***Complete all information below or authorization process 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 process 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®
❑ 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**;