

# 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 from below) (Non-Preferred) (MEDICAID/FAMIS)

<input type="checkbox"/> <b>Trulicity™</b> (dulaglutide)	<input type="checkbox"/> <b>Adlyxin®</b> (lixisenatide)
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**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:** The following criteria MUST be met to qualify to ensure authorization process will NOT be delayed.

- Patient has tried and failed at least 30 days of metformin therapy.

**\*\*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: 5/21/2015

REVISED/UPDATED: 5/27/2015; 12/29/2015; 12/20/2016; 8/18/2017; 9/14/2017; 6/18/2018; 7/16/2018