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.***

MEDICAID ONLY

Drug Requested: ***(check one below)***

- ❑ **Amitiza**® (lubiprostone)
- ❑ **Linzess**® (linaclotide)

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*: *ALL boxes below MUST be checked to qualify or authorization process will be delayed. Chart notes documenting OTC medication trials MUST be attached to request.

- **Diagnoses** ***(check one from below):***
  - ❑ Chronic Idiopathic Constipation
  - ❑ Irritable Bowel Syndrome with Constipation
  - ❑ Opioid-induced Constipation
  - ❑ Other _____

AND

❑ Member has tried and failed at least ***three (3)*** laxative therapies ***within the last 4 months:***

❑ senna	❑ bisacodyl	❑ polyethylene glycol (generic Miralax)	❑ phosphosoda enema	❑ Other_____

AND

❑ Member has tried and failed lactulose ***within the last 4 months.***

❑ Patient is ≥ 18 years of age

*****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 Pharmacy and Therapeutics Committee:** 1/15/2016
REVISED/UPDATED: ~~3/30/2016; 4/26/2016; 11/14/2016; 12/15/2016;~~ **8/9/2017**;