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. **If information provided is NOT complete, correct, or legible, authorization can be delayed.**

COMMERCIAL/FAMIS

Drug Requested:

❑ **Amitiza®** (lubiprostone)	❑ **Trulance®** (plecanatide)

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

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **MUST** be met for approval. **ALL** documentation, including labs or chart notes (if required) documenting OTC medication trials, **must** be attached to this form or request will be denied.

❑ **Diagnosis for Trulance® - Oral, 3 mg once daily.** Check below that applies**:**

- ❑ Chronic Idiopathic Constipation (CIC)

OR

- ❑ Irritable Bowel Syndrome with Constipation (IBS-C)

AND

- ❑ Trial and failure, contraindication, or intolerance to **one (1)** of the following generics:

❑ lactulose	❑ polyethylene glycol (generic Miralax)

AND

- ❑ Trial and failure, contraindication, or intolerance to Linzess®

❑ **Diagnosis for Amitiza®** - Check below that applies:

- ❑ **Chronic Idiopathic Constipation (CIC)** (Oral-24mcg twice daily) **OR**
- ❑ **Irritable Bowel Syndrome with Constipation (IBS-C)** (Females ≥ 18 years: Oral 8mcg twice daily) **OR**
- ❑ **Opioid-induced constipation** (Oral – 24mcg twice daily)
- ❑ Trial and failure, contraindication, or intolerance to one of the following generics:

❑ lactulose	❑ polyethylene glycol (generic Miralax)

AND

(continued on next page)

❑ Trial and failure, contraindication, or intolerance to **one (1)** of the following preferred brands:

❑ Linzess®	❑ Movantik®	❑ Symproic®

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:** 7/20/2017
REVISED/UPDATED: ~~9/28/2017,~~ **3/5/2019**