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.**

DRUG REQUESTED: Arikayce® (amikacin liposome inhalation suspension)

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

Drug Form/Strength: _____

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

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

Quantity limit: One vial (590mg) once daily

CLINICAL CRITERIA: The following criteria **MUST** be met. **ALL** boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed**.**

Initial Authorization – 6 months. Criteria below **must** be met to qualify. **ALL** documentation (chart notes, lab results, and/or other clinical information that supports the member met **ALL** approval criteria) **must** be attached.

- ❑ Patient must be 18 years of age or older;

AND

- ❑ Medication must be prescribed by or in consultation with an Infectious Disease Specialist;

AND

- ❑ Patient must have the following diagnosis **(Chart notes must be submitted):**
  - ❑ **Mycobacterium avium complex (MAC) lung disease** who have limited or no alternative treatment options, as part of a combination antibacterial drug regimen in patients who do not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy;

AND

  - ❑ Must submit documentation of **at least 2 positive sputum cultures** despite at least 6 months of multidrug background guideline-based therapy (**Must attach lab results**);

AND

  - ❑ Prescriber attestation to use in combination with guideline-based therapy

Reauthorization Approval - 12 months. Criteria below must be met and **ALL** documentation (chart notes, lab results, and/or other clinical information supporting the member met **ALL** approval criteria) **must** be attached.

- ❑ Must submit documentation that the patient has achieved **3 consecutive monthly negative** sputum cultures in 6 months (**Must attach lab results**).

(continued on next page; signature page MUST be attached to this request form)

Medication being provided by a Specialty Pharmacy - PropriumRx

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:** 1/17/2019
REVISED/UPDATED: 3/6/2019