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)*** ***(MEDICAID/FAMIS)***

❑ **Byetta**® (exenatide)	❑ **Bydureon**® (exenatide ER)	❑ **Victoza**® (liraglutide)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Name/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.

❑ Patient has tried and failed at least ***30 days*** of therapy with **Trulicity**™ **(*requires Prior Authorization*)**

AND

❑ Patient has tried and failed at least ***30 days*** of therapy with **Adlyxin**® ***(requires Prior Authorization)***

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

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