

# 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 ONLY**

**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 **Tanzeum™** (*requires Prior Authorization*)

AND

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

REVISED/UPDATED: 5/27/2015; 12/27/2015; 12/15/2016; 8/9/2017; 9/7/2017