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: **Endari™** (L-glutamine oral powder)

DRUG INFORMATION: ***Complete information below. Lines not completed will delay authorization process.***

Drug Form/Strength/Quantity: _____

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

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

CLINICAL CRITERIA*: *Complete ALL information below or authorization process will be delayed Medical documentation MUST be attached to this request form.

For Initial 6-Month Approval
(ALL criteria MUST be met for approval)

- ❑ Patient must be 5 years of age or older.

AND

- ❑ Patient must have a diagnosis of Sickle Cell disease

AND

- ❑ Provider must be a hematologist or oncologist specializing in treatment of Sickle Cell disease

AND

- ❑ Patient must have been compliant with hydroxyurea for at least 90 days (compliance will be documented by pharmacy paid claims)

AND

- ❑ Documentation of frequency of episodes of Sickle Cell crisis must be attached (medical chart notes from the last 6 months must be submitted including documentation of ER visits and Sickle Cell crisis events)

For Continuation of Therapy – 12 Month Approval
(ALL criteria MUST be met for continued approval)

❑ Patient must have been compliant with BOTH Endari AND hydroxyurea since last approval (monthly pharmacy claims must be noted)

AND

- ❑ The frequency of the patient's episodes of Sickle Cell crisis must have decreased since last approval of Endari (medical chart notes from the last 6 months must be submitted including documentation of ER visits and crisis events)

(signature on next page)

*****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**: 11/16/2018
REVISED/UPDATED: 2/22/2018