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: **Evekeo®** (amphetamine sulfate)

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

Drug Form/Strength: _____

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

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

***CLINICAL CRITERIA*: Boxes MUST be checked below to qualify or authorization process will be delayed.**

- Is Evekeo® being prescribed for Exogenous Obesity? ❑ Yes **OR** ❑ No
  - **IF *NO*:**
    - ❑ Patient ***must*** have tried and failed ***30 days of therapy*** **with two (2) of the following**:

❑ amphetamine-dextroamphetamine IR/ER (generic Adderall/Adderall XR)	❑ dexmethylphenidate IR/ER (generic Focalin/Focalin XR)
❑ dextroamphetamine IR/SR (generic Dextrostat/Procentra/Zenzedi/Dexedrine)	❑ methylphenidate IR/ER (generic Ritalin/Ritalin SR/Ritalin LA/Concerta/Metadate CD)

    - ❑ ***If the member is over the age of 18, the member must also meet diagnostic criteria. The prior authorization form ("CNS Stimulants- Age 19 and Older") can be downloaded from:*** **http://providers.optimahealth.com**
  - **IF *YES*: *(This is a group specific benefit)***

    The following criteria ***must*** be met:

    Height: _____ Weight: _____ Date measured: _____

    - ❑ Patient has a BMI of 40 or greater

      OR

    - ❑ Patient has a BMI of 35 with co-morbid condition(s): _____
      (may include coronary artery disease, hypertension, CHF, diabetes, dyslipidemia, or sleep apnea.)

    ***Please Note*: If medication claims documenting the co-morbid condition(s) are NOT present, chart notes must be submitted.**

******LENGTH OF AUTHORIZATION IS 4 WEEKS ONLY FOR WEIGHT LOSS******

*****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: _____

***Approved by Pharmacy and Therapeutics Committee:** 7/16/2015

REVISED/UPDATED ~~8/11/2015~~; ~~**12/27/2015**~~; ~~4/21/2016~~; ~~5/6/2016~~; 12/16/2016; ~~8/12/2017~~; **3/20/2018**