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)

(This is a group specific benefit.)

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***: _____

******LENGTH OF AUTHORIZATION IS 4 WEEKS ONLY******

CLINICAL CRITERIA*: *Boxes MUST be checked below to qualify or authorization process will be delayed. Chart notes may be required IF medication claims documenting the co-morbid condition(s) are NOT present.

- Is Evekeo® being prescribed for Exogenous Obesity? ❑ Yes **OR** ❑ No
  - **IF *NO*:**
    - ❑ **Patient has tried and failed at least *30 days* of therapy with the following**:
      - ❑ IR amphetamine/dextroamphetamine tablets (generic Adderall)

      AND

      - ❑ IR methylphenidate (generic Ritalin) **OR** ❑ IR dexmethylphenidate (generic Focalin)
    - ❑ **If the member is over the age of 19: documentation of diagnosis *MUST* be submitted. There is a specific prior authorization form (*"CNS Stimulants for Adults Age 19 and Above"*) available for download at http://providers.optimahealth.com/pharmacy for this purpose.** ***(Attach form and any additional requested documentation to this request.)***
  - **IF *YES*:**
    - ❑ 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.)

*****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**;