# 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 below)*****:** ***Insulins***

| | |
|---|---|
| ❑ **NovoLOG® vial** or **FlexPen®** (insulin aspart) | ❑ **Apidra® vial** or **SoloSTAR®** (insulin glulisine) |
| ❑ **NovoLOG® Mix 70/30 vial** or **FlexPen®** (insulin aspart protamine suspension/insulin aspart) | ❑ **Levemir® vial** or **FlexTouch®** (insulin detemir) |
| ❑ **NovoLIN® N** (insulin aspart) | ❑ **Tresiba® FlexTouch®** (insulin degludec U-100/200) |
| ❑ **NovoLIN® R** (insulin aspart) | ❑ **Basaglar®** (insulin glargine) |
| ❑ **NovoLIN® 70/30** (70% NPH insulin aspart protamine/30% Regular insulin aspart) | ❑ **Admelog®** (insulin lispro) |
| ❑ **Fiasp®** (insulin aspart) | |

***DRUG INFORMATION:* Complete all information below or authorization process will be delayed.**

**Drug Name/Form/Strength:** _____

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

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

***CLINICAL CRITERIA*: *ALL appropriate boxes must be checked to ensure authorization will NOT be delayed.***

**For NovoLOG®, NovoLIN®, Apidra®, Admelog®, and Fiasp® products, please check below: (Box *must* be checked)**

- ❑ Patient has tried and failed at least ***30 days*** of therapy with a Humalog® or Humulin® product

**For Levemir® or Tresiba® please check below: (*All* boxes *must* be checked)**

- ❑ Patient has tried and failed at least ***30 days*** of therapy with Lantus® or Toujeo®
- ❑ **For Levemir®,** is patient a pregnant female? Yes _____ No _____
  - ❑ If yes, please note expected delivery date: _____

**For Basaglar® please check below: (*All* boxes *must* be checked)**

- ❑ Patient has tried and failed at least ***30 days*** of therapy with Lantus®

**AND**

- ❑ Patient has tried and failed at least ***30 days*** of therapy with Toujeo®

**AND**

- ❑ Patient has tried and failed at least ***30 days*** of therapy with Levemir®

****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 #: _____ Member 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**: 10/15/2015

**REVISED/UPDATED:** ~~10/26/2015; 12/22/2015; 6/16/2016; 8/3/2016; 12/12/2016; 5/4/2017; 5/17/2017; 6/28/2017; 8/14/2017;~~ **6/29/2018**