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)	❑ **NovoLIN® 70/30** (70% NPH insulin aspart protamine/30% Regular insulin aspart)
❑ **NovoLIN® N** (insulin aspart)	❑ **Levemir® vial** or **FlexTouch®** (insulin detemir)
❑ **NovoLIN® R** (insulin aspart)	❑ **Tresiba® FlexTouch®** (insulin degludec U-100/200)
	❑ **Basaglar®** (insulin glargine)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

CLINICAL CRITERIA**:** ***ALL appropriate boxes must be checked to qualify or authorization process will be delayed.***

For NovoLOG®, NovoLIN® or Apidra® products, please check below: (*All* boxes *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**