

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):

Kombiglyze™ XR
(metformin extended- release and saxagliptin)

Kazano®
(metformin and alogliptin)

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: Boxes below must be met to qualify or authorization process will be delayed.

Patient has tried and failed therapy with Janumet® or Janumet XR®

AND

Patient has tried and failed therapy with Jentadueto®

****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 the Pharmacy and Therapeutics Committee: 10/15/2009

REVISED/UPDATED: 6/4/2011; 5/17/2012; 10/22/2012; 3/21/2013; 6/18/2013; 3/20/2014; 11/2/2014; 5/22/2015; 12/28/2015; 12/19/2016; 8/14/2017.