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. **If information provided is NOT complete, correct, or legible, the authorization can be delayed.**

Drug Requested (select drug below): **COMMERCIAL/FAMIS**

PREFERRED		
❑ **Linzess®** (linaclotide)	❑ **Movantik™** (naloxegol)	❑ **Symproic®** (naldemedine)
Non-Preferred		
❑ **Relistor®** (methylnaltrexone bromide)		

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

Drug Name/Form/Strength: _____

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

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

CLINICAL CRITERIA: Applicable boxes below **must** be checked to qualify or authorization process will be delayed. Chart notes of failure or OTC claims **MUST** be attached to request**.**

Part A – for approval of Movantik™ OR Symproic®, all of the following criteria must be met:

- ❑ Member has a diagnosis of opioid-induced constipation is being treated for chronic, non-cancer pain

AND

- ❑ Member has tried and failed, has contraindication or intolerance to one of the following generics:
  - ❑ Lactulose **OR** ❑ Polyethylene glycol

Part B – for approval of Relistor®, all of the following criteria must be met:

- ❑ All criteria for **Part A must** be met

AND

- ❑ Member has had a 30-day trial of Movantik™ **OR** Symproic®

Part C – for approval of Linzess®: Approval length – 12 months. All of the following criteria must be met:

- ❑ Member has a diagnosis of Chronic Idiopathic Constipation (CIC) OR Irritable Bowel Syndrome with Constipation (IBS-C)

AND

- ❑ Member has tried and failed, contraindication or intolerance to one of the following generics:
  - ❑ Lactulose **OR** ❑ Polyethylene glycol

(Continued on next page; signature page MUST be attached to this request form)

(Signature page MUST be included with request form)

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 Pharmacy and Therapeutics Committee**: 10/15/2015
REVISED/UPDATED: ~~10/29/2015~~; ~~12/22/2015~~; ~~11/14/2016~~; ~~12/19/2016~~; ~~8/15/2017~~; ~~10/13/2018~~; **(Reformatted) 3/5/2019**