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 drug below)*:**

❑ **Relistor**® (methylnaltrexone bromide)	❑ **Movantik**™ **(**naloxegol)

DRUG INFORMATION: Complete information below. If incomplete, authorization process 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.

❑ **Diagnosis**: opioid induced constipation **OR** ❑ **Diagnosis:** other: _____

❑ Does member have Pharmacy Paid claims within ***the last 6 months*** documenting stable opioid regimen

❑ Member has failed ***at least three (3)*** laxative therapies:

❑ senna	❑ bisacodyl	❑ polyethylene glycol	❑ phospho-soda enema	❑ Other_____

AND

❑ Member has tried and failed lactulose ***within the last 4 months*.**

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**;