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): **COMMERCIAL**

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

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 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®

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**