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): ***FAMIS/MEDICAID***

❑ **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. Chart notes of failure or OTC claims **MUST** be attached to request.

Part A – for 6 month approval of Movantik™ and Symproic®:

Diagnosis: Check below:

❑ opioid induced constipation	**OR**	❑ Other: _____

Member must have had pharmacy paid claims for 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.**

Part B – for 6 month approval of Relistor®:

❑ All criteria for Part A must be met

AND

❑ Member has had 30 day trial of Movantik AND Symproic

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

(Signature page MUST be included with this request.)

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;~~ **10/12/2018**