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 that applies)*:

❑ **Onglyza**™ (saxagliptin)	❑ **Nesina**® (alogliptin)
❑ **Kombiglyze™ XR** (metformin extended- release and saxagliptin)	❑ **Kazano**® (metformin and alogliptin)

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

Drug Name/Form/Strength: _____

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

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

***CLINICAL CRITERIA*: The criteria below must be met to qualify or authorization process will be delayed.**

❑ ***For Onglyza™ or Nesina®:***

- ❑ Patient has tried and failed therapy with Januvia®

AND

- ❑ Patient has tried and failed therapy with Tradjenta®

❑ ***For Kombiglyze™ XR or Kazano®:***

- ❑ 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: ~~6/10/2011; 8/22/2011; 5/17/2012; 10/9/2012; 3/21/2013; 6/18/13; 4/10/2014; 11/2/2014; 5/22/2015; 12/28/2015; 12/22/2016; 8/15/2017;~~ **6/18/2018**;