

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: **Saxenda® (liraglutide)**

This is a group specific benefit.

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

*****LENGTH OF AUTHORIZATION IS 16 WEEKS ONLY*****

Continued approval is contingent upon patient continuing to lose/maintain weight up to the desired BMI

▪ *Pregnancy Category X*

CLINICAL CRITERIA: Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed. Chart /progress notes MUST be attached to this request.

<input type="checkbox"/>	Height: _____ Weight: _____ Date measured: _____						
<input type="checkbox"/>	Patient has a BMI of 40 or greater OR						
<input type="checkbox"/>	Patient has a BMI of 35 with co-morbid condition(s): _____ (may include coronary artery disease, hypertension, CHF, diabetes, dyslipidemia, or sleep apnea.) <i>Please note: if medication claims documenting the co-morbid condition(s) are not present, chart notes may be requested</i>						
<input type="checkbox"/>	Trial and failure of at least <u>one full course (defined below) of TWO (2)</u> of the following: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Adipex-P® (phentermine HCl)- 16 weeks</td> <td><input type="checkbox"/> Belviq® (lorcaserin)- 12 weeks</td> </tr> <tr> <td><input type="checkbox"/> Suprenza® (phentermine HCl)- 16 weeks</td> <td><input type="checkbox"/> Xenical® (orlistat)- 16 weeks</td> </tr> <tr> <td><input type="checkbox"/> Contrave® (naltrexone HCl/bupropion HCL)- 12 weeks</td> <td><input type="checkbox"/> Qsymia® (phentermine/topiramate ER)- 16 weeks</td> </tr> </table> <i>NOTE: if a full course of medication could NOT be achieved due to intolerance/adverse event, submit documentation (chart/progress notes).</i>	<input type="checkbox"/> Adipex-P® (phentermine HCl)- 16 weeks	<input type="checkbox"/> Belviq® (lorcaserin)- 12 weeks	<input type="checkbox"/> Suprenza® (phentermine HCl)- 16 weeks	<input type="checkbox"/> Xenical® (orlistat)- 16 weeks	<input type="checkbox"/> Contrave® (naltrexone HCl/bupropion HCL)- 12 weeks	<input type="checkbox"/> Qsymia® (phentermine/topiramate ER)- 16 weeks
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<input type="checkbox"/> Contrave® (naltrexone HCl/bupropion HCL)- 12 weeks	<input type="checkbox"/> Qsymia® (phentermine/topiramate ER)- 16 weeks						

*****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: 7/16/2015

REVISED/UPDATED: 8/11/2015; 12/29/2015; 12/19/2016; 8/17/2017