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; **(Pharmacy) 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested (check below that applies):

❑ **Soliqua®** (insulin glargine and lixisenatide injection)	❑ **Xultophy®** (insulin degludec and liraglutide injection)

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

Drug Name/Form/Strength: _____

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

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

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria must be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

❑ Patient has tried and failed at least ***30 days*** of therapy with ***one*** of the following:

- **Glucagon-Like Peptide 1 Receptor Agonist:**

❑ Byetta®	❑ Trulicity®
❑ Bydureon®	❑ Victoza®
❑ Ozempic®	

AND

- **Long-Acting Insulin:**

❑ Lantus®	❑ Toujeo®

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:** 7/20/2017
REVISED/UPDATED: ~~9/14/2017; 7/30/2018;~~ **3/25/2019**