

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 one from below)

(COMMERCIAL ONLY)

<input type="checkbox"/> Tanzeum® (albiglutide)	<input type="checkbox"/> Adlyxin™ (lixisenatide)
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DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: ALL boxes must be checked to qualify or authorization process will be delayed. Chart notes MUST be attached to this request.

Patient has tried and failed at least 30 days of therapy with two (2) of the following:

<input type="checkbox"/> Byetta®	<input type="checkbox"/> Victoza®
<input type="checkbox"/> Bydureon®	<input type="checkbox"/> Trulicity®

****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: 7/19/2012; 2/22/2017

REVISED/UPDATED: 9/28/2012; 7/17/2014; 7/22/2014; 9/26/2014; 10/7/2014; 10/8/2014; 11/5/2014; 3/19/2015; 4/29/2015; 5/27/2015; 12/29/2015; 12/20/2016; 2/22/2017; 3/20/2017; 8/18/2017; 9/14/2017