OPTIMA HEALTH PLAN

PHARAMCY 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: Tiglutik™ (riluzole) **oral suspension**

DRUG INFORMATION: Complete information below or authorization will be delayed if incomplete.

Drug Form/Strength: _____

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

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

Recommended dosage: 50mg twice daily

Quantity Limit: 600mL/30 days

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 **MUST** have a diagnosis of Amyotrophic lateral sclerosis (ALS);

AND

- ❑ Patient had a trial and failure or intolerance to generic riluzole tablets **(VERIFIED THROUGH PHARMACY PAID CLAIMS AND SUBMITTED CHART NOTES)**

OR

- ❑ Patient is unable to ingest a solid dosage form (e.g. an oral tablet) due to one or more of the following:
  - ❑ Age
  - ❑ Oral/motor difficulties
  - ❑ Dysphagia
  - ❑ Member is utilizing a feeding tube for medication administration

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**: 3/21/2019;
REVISED/UPDATED: 5/15/2019;