

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.**

FAMIS MEMBERS ONLY

Drug Requested: Trulance® (plecanatide)

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

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: **ALL** boxes below **MUST** be checked to qualify to ensure authorization will **NOT** be delayed. Chart notes documenting OTC medication trials **MUST** be attached to request.

- Patient is ≥ 18 years of age
- Patient diagnosed with Chronic Idiopathic constipation

AND

- Member has tried and failed at least **three (3)** laxative therapies **within the last 4 months:**

<input type="checkbox"/> senna	<input type="checkbox"/> bisacodyl	<input type="checkbox"/> polyethylene glycol (generic Miralax)
<input type="checkbox"/> phosphosoda enema	<input type="checkbox"/> Other: _____	

AND

- Member has tried and failed lactulose **within the last 4 months.**

****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 #: _____