

# 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:** **Xultophy®** (insulin degludec and liraglutide injection) **Commercial Only**

**DRUG INFORMATION:** Complete information below. If incomplete, authorization process will be delayed.

Drug Name/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.

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

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

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

**AND**

- **Long-Acting Insulin:**

<input type="checkbox"/> Lantus®	<input type="checkbox"/> Toujeo
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**\*\*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 #: \_\_\_\_\_