OPTIMA HEALTH PLAN

PHARMACY/MEDICAL 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. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Xenleta™ (lefamulin)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug 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. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ The patient has a diagnosis for Community-Acquired Bacterial Pneumonia

FOR OUTPATIENT TREATMENT: Chart notes, medication orders/history need to accompany this request. All will be verified through Pharmacy Claims

- ❑ The patient has tried and failed the following therapies:
  - ❑ amoxicillin

    AND
  - ❑ doxycycline

    AND
  - ❑ macrolide antibiotic (azithromycin or clarithromycin)

OR

- ❑ **FOR PATIENTS WITH COMORBIDITIES** (such as chronic heart, lung, liver or renal disease, diabetes mellitus, alcoholism, malignancy or asplenia) the following therapies have been tried:
  - ❑ Combination therapy with amoxicillin/clavulanate or cephalosporin (cefpodoxime or cefuroxime) AND a macrolide antibiotic or doxycycline

    AND
  - ❑ Monotherapy with a respiratory fluoroqunolone (levofloxacin, moxifloxacin, gemifloxacin)
- ❑ Document any intolerabilities/contraindications/resistance to the above therapies (include medical documentation):

_____

_____

_____

(Continued on next page)

IF TREATMENT WAS STARTED IN AN INPATIENT SETTING: Chart notes, medication orders/history need to accompany this request. All will be verified through Pharmacy Claims

- ❑ The patient has tried and failed the following therapies:
  - ❑ Beta-lactam antibiotic (ampicillin/sulfabactam, cefotaxime, ceftriaxone) PLUS a macrolide antibiotic

    AND
  - ❑ Monotherapy with a respiratory fluoroquinolone

    AND
  - ❑ Beta-lactam antibiotic PLUS doxycycline
- ❑ Document any intolerabilities/contraindications/resistance to the above therapies (include medical documentation):

_____

_____

_____

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****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**: 1/16/2020
REVISED/UPDATED: 2/24/2020