

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

Irritable Bowel Disease (IBD) (NON-PREFERRED) (Commercial Only)

DRUG REQUESTED - Check box below that applies:

- | | |
|--|--|
| <input type="checkbox"/> Mesalamine DR 800mg (generic Asacol [®] HD) | <input type="checkbox"/> Dipentum[®] (olsalazine) |
| <input type="checkbox"/> budesonide ER 9mg (generic Uceris [®]) | <input type="checkbox"/> Uceris[®] (budesonide ER 9mg) |

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.

☐ **Approval of mesalamine DR 800mg (generic Asacol[®] HD)**

- ☐ Member has had trial and failure of **at least 30 days of therapy** with mesalamine 0.375gm (generic Apriso[®]), mesalamine 400mg (generic Delzicol[®]) or mesalamine 1.2gm (generic Lialda[®])

☐ **Approval of Dipentum[®] (olsalazine)**

- ☐ Member has had trial and failure of **at least 30 days of therapy** with generic balsalazide (at doses recommended for treatment of ulcerative colitis[UC]) or sulfasalazine (at doses recommended for UC & Crohn's disease)

☐ **For maximum 8 week approval of budesonide ER 9mg (Uceris[®])**

- ☐ Medication is being requested for induction of remission in member with active mild to moderate ulcerative colitis
- ☐ Member has had trial and failure of **at least 30 days of therapy** with delayed-release budesonide 3mg capsules taken at a dose of 9mg/day

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

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.****

Member 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: 10/19/2017

REVISED/: 12/13/2017; 2/16/2018; (Reformatted) 1/30/2019; 8/13/2019; 8/31/2020