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: Egrifta™ (tesamorelin)

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

Drug Form/Strength: _____

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

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

- ***Recommend dose:*** **2 mg injected subcutaneously once daily.**

CLINICAL CRITERIA: Box MUST be checked to qualify. Incomplete information will delay authorization process.

- ❑ Patient is HIV-positive with lipodystrophy.

Medication being provided by (check applicable box below):

- ❑ **Physician's office**

OR

- ❑ **Specialty Pharmacy**: ❑ **PropriumRx**

*****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 the Pharmacy and Therapeutics Committee**: 7/21/2011
REVISED/UPDATED: 9/19/2011; 4/10/2014; 8/8/2014; 10/30/2014; 5/21/2015; 12/27/2015; 8/12/2016; 9/22/2016; 12/11/2016; **8/3/2017**