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; **(Pharmacy) 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 can be delayed.**

Drug Requested: Mytesi™ (crofelemer)

DRUG INFORMATION: Complete information below or authorization will 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. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

- ❑ Patient must be ≥ 18 years old
- ❑ Patient has HIV/AIDS on anti-retroviral therapy **(claims history evident within past 30 days)**
- ❑ Patient has non-infectious diarrhea
- ❑ Patient has tried **one (1)** of the following:
  - ❑ loperamide (Imodium®)

    OR
  - ❑ diphenoxylate / atropine (Lomotil®)

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:** 5/16/2013
REVISED/UPDATED: ~~9/30/2013; 10/30/2014; 5/21/2015; 12/27/2015; 12/16/2016; 3/1/2017; 8/15/2017;~~ **(Reformatted) 6/19/2019**;