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

Drug Requested: Select one below:

❑ **alogliptin** (generic Nesina® ABA)	❑ **Nesina®** (alogliptin)
❑ **alogliptin and pioglitazone** (generic Oseni® ABA)	❑ **Oseni®** (alogliptin and pioglitazone)
❑ **metformin and alogliptin** (generic Kazano® ABA)	❑ **Kazano®** (metformin and alogliptin)
❑ **Kombiglyze™ XR** (metformin extended-release and saxagliptin)	❑ **Onglyza™** (saxagliptin)

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.

For Nesina®, Onglyza™, Oseni®, alogliptin, or alogliptin and pioglitazone

- ❑ Patient has tried and failed **90 days** of therapy with Januvia®

AND

- ❑ Patient has tried and failed **90 days** of therapy with Tradjenta®

For Kazano®, Kombiglyze™ XR, or metformin and alogliptin

- ❑ Patient has tried and failed **90 days** of therapy with Janumet® **or** Janumet® XR

AND

- ❑ Patient has tried and failed **90 days** of therapy with Jentadueto®

(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.****

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:** 10/15/2009
REVISED/UPDATED: ~~6/10/2011; 8/22/2011; 5/17/2012; 10/9/2012; 3/21/2013; 6/18/13; 4/10/2014; 11/2/2014; 5/22/2015; 12/28/2015; 12/22/2016; 8/15/2017; 6/18/2018; (Reformatted) 6/19/2019;~~ **6/4/2020**