# 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 can be delayed.**

**Drug Requested: Auvi-Q®** (epinephrine injection) **Auto-Injector**

**Strength Requested (select one below):**

| | | |
|---|---|---|
| ❑ **Auvi-Q® 0.1mg** | ❑ **Auvi-Q® 0.15mg** | ❑ **Auvi-Q® 0.3mg** |

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength:** _____

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

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

Chart notes documenting administration and failure of EpiPen® product or its generic resulting in medical intervention, such as an emergency room visit, **MUST** be attached to this request form or authorization could be delayed.

**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 Auvi-Q® 0.1mg (for patients > 5 years of age only)**:
  - ❑ Patient must weigh 7.5-15kg (chart notes documenting current weight must be submitted)

    **AND**
  - ❑ Authorization will be approved for 12 months, then reauthorization is required
- ❑ **For Auvi-Q® 0.15mg and 0.3mg**:
  - ❑ Patient experienced treatment failure with EpiPen®, EpiPen Jr® or generic EpiPen®/Jr and resultant medical intervention was required.

***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**: 1/21/2016
**REVISED/UPDATED**: 3/29/2016; 4/20/2017; 5/17/2017; 8/9/2017; 9/26/2018; **(Reformatted)** 5/28/2019; **6/21/2021**