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.**

Drug Requested: Tiglutik® (riluzole) **oral suspension**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Quantity Limit: 600 mL per 30 days

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.

- ❑ Member has a diagnosis of amyotrophic lateral sclerosis (ALS)
- ❑ Member must meet **ONE** of the following:
  - ❑ Member tried and failed, has an intolerance or contraindication to generic riluzole tablets **(must submit chart notes to document therapeutic failure, intolerance or contraindication)**
  - ❑ Member is unable to ingest a solid dosage form (e.g., an oral tablet) due to at least **ONE** of the following **(check all that apply)**:
    - ❑ Age
    - ❑ Oral/motor difficulties
    - ❑ Dysphagia
    - ❑ Member is utilizing a feeding tube for medication administration

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**: 3/21/2019;
REVISED/UPDATED: ~~5/15/2019;~~ **12/6/2022**;