OPTIMA HEALTH PLAN

MAXIMUM DAILY DOSAGE LIMIT EXCEPTIONS 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 INFORMATION: All information below must be completed. If incomplete or boxes are not checked, outcome of this request may be affected and authorization process will be delayed.

REQUESTED MEDICATION/DRUG NAME: ____________________

- **Dosage Form** ***(tab, liquid, patch)***: ____________________ **Strength**: ____________________

❑ **Newly Prescribed Therapy** ***OR*** ❑ **Refill Therapy**

Dosing Schedule: ____________________ **Length of therapy**: ____________________

Qty per 30 Day Supply: ____________________

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

If diagnosis is pain, is this cancer pain? ❑ Yes ❑ No

CLINICAL REASON FOR DOSAGE REQUESTED: Information MUST be provided below or authorization process will be delayed. Attach ALL chart notes/documentation to this request.

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PREVIOUS THERAPIES FAILED AND/OR THERAPIES CURRENTLY USED IN COMBINATION WITH THE REQUESTED MEDICATION: List ALL medications tried or authorization process will be delayed.

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Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If Yes, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature). Attach additional pages if necessary.

****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**: 2/21/2013
REVISED: ~~6/3/2014; 10/30/2014; 5/22/2015; 12/29/2015; 12/7/2016;~~ **9/12/2017**;