OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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. **Incomplete forms will delay the authorization process**.

Drug Requested: **Compound Drug(s)**

INGREDIENTS:

Drug	Strength	Drug	Strength
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The Compound must contain at least one FDA-approved prescription drug and the prescription ingredients must be in therapeutic amounts recognized by national compendia or peer-reviewed medical literature.

Indication: _____

Dosage form of compound: _____

The following criteria must be met:

- ❑ National Compendia reference or two (2) peer-reviewed randomized controlled trials supporting the efficacy and safety of this compound are attached to this request.

AND

- ❑ Patient has **tried and failed at least three (3)** FDA-approved commercially available therapeutic alternatives **AND** at **least one** of the alternatives is of the same route of administration as the compound:
  - o **Drug** _____ **Route of administration**: _____
  - o **Drug** _____ **Route of administration**: _____
  - o **Drug** _____ **Route of administration**: _____

AND

- ❑ The strength requested is **not** commercially available

Compounds containing the following must be in the same dosage form as commercially available specific drug products: diclofenac, flurbiprofen, fluticasone, gabapentin, ketamine, ketoprofen, levoceterizine and mometasone.

Compounds used for cosmetic indications are **excluded** from the benefit and will be **denied.**

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 #: _____ Member Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~6/29/2017,~~ **9/18/2018**