OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY/MEDICAL DRUG NECESSITY 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**.

This form is intended for use when a medication being requested is:

- **A specific preauthorization form is not available**

DRUG INFORMATION: **ALL** information below **MUST** be completed or authorization process will be delayed.

Drug/Medication Name: ____

Strength/Form: ____

Diagnosis/Indication: ____________________________ **Duration of therapy:** ____________________

PREVIOUS THERAPIES FAILED: Complete information below to ensure authorization will **NOT** be delayed.

Medication Name	Dose	Length of Trial
1.________________________	______________	______________________
2.________________________	______________	______________________
3.________________________	______________	______________________

Has the patient failed previous treatment and shown intolerance, or has a contraindication to the covered alternatives? ❑ **Yes** ❑ **No**

If **Yes**, please describe **AND** attach chart notes. If incomplete, authorization process will be delayed.

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(Continued on next page; signature page MUST be attached to this request.)

(Signature page MUST be included with this form.)

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 #: ____

REVISED/UPDATED: ~~9/18/2018;~~ **10/8/2018**