OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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.**

Requested Medication: _____ Strength: _____

Dosage Form **(tab, liquid, patch)**: _____

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

Dosing Instructions: _____

Anticipated duration of therapy:_____ Qty per 30 Day Supply: _____

Diagnosis for this Drug or ICD Code: _____

If diagnosis is pain, is this cancer pain? _____

Reason for Request: _____

Other Medications Currently Used in Combination with the Requested Medication for the Treatment of this Diagnosis:

_____

_____

Therapies Tried: _____

_____

_____

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.)**

_____

_____

(continued on next page)

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 #: _____ Date Requested: _____

REVISED: ~~6/29/2017;~~ ~~9/5/2017;~~ **9/18/2018**