

OPTIMA COMMUNITY CARE (MEDICAID)

NON-PREFERRED DRUG REQUEST FORM FOR MEDICAL NECESSITY

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 information provided is not complete, correct, or legible, authorization may be delayed.**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____
 Member Optima #: _____ Date of Birth: _____
 Prescriber Name: _____
 Prescriber Signature: _____ Date: _____
 Office Contact Name: _____
 Phone Number: _____ Fax Number: _____
 DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____
 Dosing Schedule: _____ Length of Therapy: _____
 Diagnosis: _____ ICD Code: _____
 Weight: _____ Date: _____

PRESCRIPTION/MEDICAL HISTORY: List previous alternative medications that have been utilized

Medication Name	Dose	Length of Trial	Outcome
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

(Continued on next page)

CLINICAL CRITERIA/MEDICAL NECESSITY: Provide clinical evidence that the **PREFERRED** drug(s) will not provide adequate benefit. Attach chart notes.

*****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.****