

# OPTIMA HEALTH PLAN

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

**This form is intended for use when a medication being requested is:  
Non-Formulary and/or a specific preauthorization form is not available.**

**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: \_\_\_\_\_

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

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

(Continued on next page)

Has the member 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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***\*\*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.\****