OPTIMA FAMILY CARE MEDALLION 4.0

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 form will delay authorization process.*

Drug Requested *(select one below)*: *Atypical Antipsychotics (Non-Preferred)*

❑ **Abilify**® (aripiprazole) tab and IM	❑ aripiprazole ODT	❑ **Clozaril**® (clozapine)	❑ clozapine ODT
❑ **Fanapt**® (iloperidone) tab & titration pk	❑ **FazaClo**® (clozapine)	❑ **Geodon**® (ziprasidone HCl)	❑ **Invega**® (paliperidone)
❑ olanzapine IM	❑ paliperidone ER	❑ **Rexulti**® (brexpiprazole)	❑ **Risperdal**® (risperidone)
❑ **Saphris**® **SL** (asenapine)	❑ **Seroquel IR**® (quetiapine)	❑ **Seroquel XR**® (quetiapine)	❑ **Symbyax**® (olanzapine & fluoxetine hydrochloride)
❑ **Versacloz**™ (clozapine, USP)	❑ **Vraylar**™ (cariprazine)	❑ **Zyprexa**® (olanzapine)	

***DRUG INFORMATION:* Complete all information below or authorization process will be delayed.**

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable***: _____

- ***If diagnosis is any type of depressive disorder, please list current antidepressant therapy:***

_____

_____

CLINICAL CRITERIA*: *ALL boxes must be checked to ensure authorization process will NOT be delayed.

❑ Patient has tried and failed ***at least 30 days*** of therapy with ***two (2)*** of the following:

❑ aripiprazole soln & tab	❑ clozapine tab	❑ Geodon® IM (ziprasidone HCl)
❑ Latuda® (lurasidone)	❑ olanzapine ODT/tab	❑ olanzapine/fluoxetine
❑ quetiapine tab	❑ quetiapine fumarate ER	❑ risperidone ODT/soln/tab
❑ ziprasidone capsule		

*****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: 7/1/2018