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 the authorization process.*

Drug Requested: ***Long-Acting Beta Adrenergics (LABAs) for Children (MEDICAID)***

***DRUG INFORMATON**: Each drug listed below will require a PA for ages less than the FDA/PI indicated age. Check applicable box below. Complete all information or authorization process will be delayed.*

Brand Name	Age where PA is required	FDA Indications
❑ Advair® Diskus 250/50, & 500/50	Children < 12 years	Asthma & COPD
❑ Advair® HFA	Children < 12 years	Asthma & COPD
❑ Advair® Diskus 100/50	Children < 4 years	Asthma & COPD
❑ Airduo™ Respiclick®	Children < 12 years	Asthma only
❑ Anoro™ Ellipta™	Children & Adolescents < 18 years	COPD only
❑ Arcapta® Neohaler	Children & Adolescents < 18 years	COPD only
❑ Bevespi Aerosphere™	Children & Adolescents < 18 years	COPD only
❑ Breo Ellipta®	Children & Adolescents < 18 years	Asthma & COPD
❑ Brovana®	Children & Adolescents < 18 years	COPD only
❑ Dulera®	Children < 12 years	Asthma only
❑ fluticasone/salmeterol pow	Children < 12 years	Asthma only
❑ Foradil® Aerolizer	Children < 5 years	Asthma & COPD
❑ Perforomist®	Children & Adolescents < 18 years	COPD only
❑ Serevent® Diskus*	Children < 4 years	Asthma & COPD
❑ Stiolto™ Respimat®	Children < 18 years	COPD only
❑ Striverdi® Respimat®	Children < 18 years	COPD only
❑ Symbicort®	Children < 12 years	Asthma & COPD

Drug Name/Form: ______________________________ **Strength:** ________________

Dosing Schedule: ______________________________ **Length of Therapy:** ____________

Diagnosis: ______________________________ ***ICD Code, if applicable:*** __________

LENGTH OF AUTHORIZATON: **3 months**

(continued on next page)

***CLINICAL CRITERIA**: The following criteria **MUST** be met to ensure authorization process will NOT be delayed.*

- Trial and failure of at least ***two (2) Preferred*** drugs in the category? ❑ Yes ❑ No

  If ***No*****,** explain rationale why the **Preferred** drugs will not provide adequate benefit. ___________________________

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***MEDICAL NECESSITY**: Provide clinical documentation why the medication requested is to be used for less than the FDA/PI indicated age.*

*****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