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 forms will delay the authorization process.***

Drug Requested: **Oral Antifungals *(Non-Preferred)*** ***(MEDICAID)***

DRUG INFORMATION: ***Check all that apply below to ensure authorization process will NOT be delayed.***

All Non-Preferred Medications (requires PA)

❑ Ancobon®	❑ clotrimazole (mucous mem)	❑ Cresemba®	❑ Diflucan® tab/susp	❑ flucytosine
❑ Gris-Peg®	❑ griseofulvin tab	❑ griseofulvin ultramicrosize	❑ Itraconazole	❑ ketoconazole
❑ Lamisil® tab	❑ Lamisil® granules	❑ Noxafil®	❑ Onmel®	❑ Sporanox® cap/sol
❑ Terbinex™ kit	❑ Vfend® tab/susp	❑ voriconazole tab	❑ voriconazole powder for susp	

Drug Name/Form: _____ **Strength:** _____

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

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

DIAGNOSIS AND MEDICAL INFORMATION: ***Complete all information below to ensure the authorization process will NOT be delayed.***

1. Has the Recipient tried and failed any of the **Preferred Oral** Antifungals? ❑ Yes ❑ No

   Check below ***ALL*** that:

❑ fluconazole tab/susp	❑ Grifulvin V® tab	❑ Griseofulvin® susp
❑ nystatin tab	❑ nystatin susp	❑ terbinafine

   Submit ALL supporting documentation of drug regimen and therapeutic failure

2. Does the Recipient have any contraindications or intolerances to any of the **Preferred** agents listed in question 1? ❑ Yes ❑ No

   If Yes, document the specialty: _____

3. Does the Recipient have a diagnosis for which none of the **Preferred Oral** Antifungals are indicated or widely medically-accepted? ❑ Yes ❑ No

   Check below ***ALL*** that apply or indicate diagnosis:

❑ aspergillosis	❑ blastomycosis	❑ histoplasmosis
❑ mucormycosis	❑ other _____	

   Submit documentation of diagnosis and planned duration of treatment.

_____

_____

****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