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: **Colcrys**™ (colchicine, USP) ***(Non-Preferred)*** ***(MEDICAID)***

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

Drug Form: _____ **Strength**: _____

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

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

Length of Authorization: **1 year**

CLINICAL CRITERIA: ***Applicable box must be checked to ensure authorization will NOT be delayed.***

- ❑ Patient has diagnosis of Familial Mediterranean Fever;

  OR

- ❑ Acute Gout Flare:
  - ❑ Trial and failure of one of the following:
    - ❑ NSAID or corticosteroid

*****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**