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 ***(please select applicable drug below)*:** ***(MEDICAID)***

Immunodulators Atopic Dermatitis

Preferred Drugs	**Non-Preferred Drugs**
❑ Elidel® (pimecrolimus)	❑ Eucrisa™ (crisaborole) ❑ Protopic® (tacrolimus) ❑ tacrolimus (generic)

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:*** _____

Length of Authorization:* *1 year

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

❑ Patient must have an FDA-approved diagnosis of Atopic dermatitis

AND

❑ **Elidel®** and **Eucisa™**: for mild to moderate for ages > 2 years.

❑ **Protopic®** 0.03%: moderate to severe for ages > 2 years

❑ **Protopic®** 0.1%: moderate to severe for ages > 18 years

AND

❑ Failure of ***at least 2*** **topical corticosteroids** *(i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)* ***(Please list drugs below)***

1. _____ **2.** _____

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**