

# 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: Enstilar® (calcipotriene and betamethasone dipropionate) Foam (Medicaid)  
(Non-Preferred)**

**DRUG INFORMATION:** 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: 4 weeks

**CLINICAL CRITERIA:** The following criteria MUST be met or authorization process will be delayed.

Patient has a diagnosis of plaque psoriasis

**AND**

Patient is  $\geq$  18 years

*\*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