

# 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: Hemangeol™ (propranolol hydrochloride) (Non-Preferred) (MEDICAID)**

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

Drug Form: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

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

- Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy

**AND**

- Member's age must be between 5 weeks and 5 months

***\*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