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: ***Kapvay® SR 12H (clonidine hydrochloride extended-release) (MEDICAID)***

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

Drug Form/Strength: _____

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

Quantity Requested: _____ **Total Daily Dose:** _____

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

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

- Trial and failure of at least **one (1) *Preferred*** drug

List medications attempted and the outcome: _____

_____

_____

***MEDICAL NECESSITY:* Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this patient.**

_____

_____

_____

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: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018