

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY STEP-EDIT AUTHORIZATION 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: MuGard® (oral mucoadhesive)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

RECOMMENDED USE: 4-6 times a day for management of oral mucositis/stomatitis.

MAX dose of MuGard: 1 bottle (8 fluid ounces/240 mL) per fill

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. ALL chart notes and lab results MUST be attached to request. Incomplete documentation will delay authorization process.

Has the member tried and failed (*paid claims will be documented*):

Oramagic Plus for at least 30 days?

AND

Magic Mouthwash for at least 30 days?

Medication being provided by a Specialty Pharmacy: Sentara Norfolk General CM Pharmacy

****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