

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: Platelet Inhibitors (Non-Preferred) (MEDICAID)

Check applicable drug below:

<u>Preferred Drugs</u>			<u>Non-Preferred Drugs</u>		
<input type="checkbox"/> Brilinta®	<input type="checkbox"/> clopidogrel	<input type="checkbox"/> dipyridamole	<input type="checkbox"/> Aggrenox®	<input type="checkbox"/> ASA/dipyridamole	<input type="checkbox"/> Durlaza® ER
<input type="checkbox"/> Effient®	<input type="checkbox"/> ticlopidine HCL		<input type="checkbox"/> Persantine®	<input type="checkbox"/> Plavix®	<input type="checkbox"/> Yosprala® tab
			<input type="checkbox"/> Zontivity®		

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: _____

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

- Aspirin is covered without a Prior Authorization.
- Trial and failure of **two (2) Preferred** drugs. *Please list drugs tried and failed.*

MEDICAL NECESSITY: Provide clinical reason below why aspirin cannot be used.

****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 #: _____