

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: Proton Pump Inhibitors (PPI) Drugs (Non-Preferred) (MEDICAID)

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

Drug Name/Form: _____ Strength: _____

Dosing Schedule/Frequency: _____ Length of Therapy: _____

Length of Authorization: 12 weeks; unless patient meets an exception, then 1 year

CLINICAL CRITERIA: The information below **MUST** be completed or authorization process will be delayed.

Initial Request Renewal Request

NOTE: PDL Criteria **must** be met first before a non-preferred PPI may be approved.

- **Initial requests** - may be authorized for **12 weeks only**.
- **Renewal requests** - may be allowed for **1 year** if one of the following exceptions has been met:
 - Patient under the care of a Gastroenterologist **OR** patient has a diagnosis of **ACTIVE** GI Bleed, Erosive Esophagitis, or Zollinger-Ellison Syndrome.
- Has the patient had a therapeutic failure of no less than a **3-month trial of at least TWO preferred PPIs**? Yes No
If **Yes**, list medications.
 - **Drug 1:** _____ Strength: _____ Start Date: _____
 - **Drug 2:** _____ Strength: _____ Start Date: _____
 - **Drug 3:** _____ Strength: _____ Start Date: _____If **No**, document compelling details. _____
- Has this patient seen a Gastroenterologist? Yes No
If **Yes**, document name: _____
- Does this patient have one of the following conditions?
 - ACTIVE GI Bleed Yes No
 - Erosive Esophagitis Yes No
 - Zollinger-Ellison Syndrome Yes No

MEDICAL NECESSITY: Provide clinical evidence that the **Preferred agent(s)** **will not** provide adequate benefit.

****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 #: _____