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: *Quinolones (Non-Preferred)* ***(MEDICAID ONLY)***

Check applicable drug below		
❑ Cipro® IR & XR & susp	❑ ofloxacin	❑ levofloxacin
❑ ciprofloxacin ER	❑ Avelox®	❑ moxifloxacin
❑ Noroxin®	❑ Levaquin® tab/susp	

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

Drug Name/Form/Strength: ____________________

Dosing Frequency: ____________________ **Length of Therapy**: ____________________

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

***Length of Authorization:** ONE TIME ONLY; no refills*

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

❑ Infection caused by an organism resistant to ciprofloxacin and levofloxacin? ❑ Yes ❑ No

OR

❑ Therapeutic failure to no less than a ***three-day trial of ciprofloxacin OR levofloxacin***? ❑ Yes ❑ No

OR

❑ Member is completing a course of therapy with a non-preferred drug which was initiated in the hospital? ❑ Yes ❑ No

****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