

# 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:** Soolantra® (ivermectin 1% topical cream)

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

**Drug Form/Strength/Quantity per Day:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_ **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code, if applicable:** \_\_\_\_\_

**Maximum Quantity:** 30 grams allowed per prior authorization

**CLINICAL CRITERIA:** To receive a **THREE (3) month** approval for this drug, **ALL** appropriate boxes below **must** be checked to qualify or authorization process will be delayed.

**Does member meet the following criteria?**

- Is member 18 years of age or older?  Yes  No
- Diagnosis of rosacea?  Yes  No
- Has member experienced treatment failure with another rosacea medication?  Yes  No
- Is member currently being treated with another topical or oral medication indicated for rosacea?  Yes  No

**Drug Name:** \_\_\_\_\_ **Date received:** \_\_\_\_\_

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**MEDICAL NECESSITY:** Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request or authorization process will be delayed.

**\*\*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 #:** \_\_\_\_\_