

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: **Topical Antifungals (Non-Preferred)** **(MEDICAID)**

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

Drug Name/Form: _____ Strength: _____
Dosing Schedule: _____ Length of Therapy: _____
Diagnosis: _____ ICD Code, if applicable: _____
Quantity per Day: _____

CLINICAL CRITERIA AND DIAGNOSIS: Answer **ALL** questions to facilitate processing. If not checked, authorization process will be delayed.

Topical Onychomycosis Agents

(to receive a **ONE (1) year approval** for these drugs, please complete the questions below.)

Does the patient meet the following criteria?

- Diagnosis of onychomycosis? Yes No
- Diagnosis of athlete's foot (tinea pedis) or ringworm (tinea cruris, tinea corporis) Yes No
- Is the patient 18 years of age or older? Yes No
- **Penlac®**, **CNL-8™**, **Jublia®**: must have failure of an adequate trial of 1 oral alternative – Yes No
terbinafine (6 weeks for fingernail infections; 1 week for toenail infections); fluconazole (6 months);
itraconazole (60 days for fingernail infections; 90 days for toenail)
- **Luzu®**: must have failure of an adequate trial of **two (2) preferred** topical antifungal medications, **OR** Yes No
Allergy or contraindication to oral terbinafine, fluconazole or itraconazole? Yes No

MEDICAL NECESSITY: Provide clinical evidence that supports the use of the requested medication.

****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 #: _____