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 form will delay authorization process.***

Drug Requested (*please select one*): ***Topical Immunomodulators***

❑ **Zyclara**® (imiquimod) **2.5% Pump**	❑ **Veregen**® (sinecatechins) **Ointment**
❑ **Zyclara**® (imiquimod) **3.75% Packets/Pump**	❑ **Solaraze**® (diclofenac) **3% Gel**

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*: *ALL boxes must be checked to qualify or authorization process will be delayed..

For Actinic Keratosis:

(Both boxes must be checked)

- ❑ Patient has a diagnosis of actinic keratosis
- ❑ Requested product:
  - ❑ Zyclara® 2.5% Pump
  - ❑ Zyclara® 3.75% Packets/Pump
  - ❑ Solaraze® 3% Gel

For External Genital and Perianal Warts/Condyloma Acuminata:

(Two boxes must be checked)

- ❑ Patient has a diagnosis of external genital and/or perianal warts/condylomata acuminata

AND

- ❑ Patient has a documented trial and inadequate response or clinically significant adverse reaction to generic Aldara™ 5% cream ***(submit chart notes)***

OR

- ❑ Patient has a documented trial and inadequate response or clinically significant adverse reaction to topical podofilox ***(submit chart notes)***

*****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**