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: ***Topical Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) (Non-Preferred) (MEDICAID)***

Preferred Drugs	Non-Preferred Drugs
❑ Voltaren® 1% gel (diclofenac sodium gel)	❑ diclofenac sodium 1% gel ❑ diclofenac sodium 3% gel ❑ Flector® patch (***QL***) ❑ Pennsaid® top soln, soln pkt & pump ❑ Solaraze® 3% top gel ❑ Vopac™ MDS ❑ Xrylix™ Kit

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

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

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

Length of Authorization*: *1 year ***Quantity Limit for Flector® - 30 patches per Rx***

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

- Approval is based on member failing the ***oral generic of the desired drug AND*** at least ***one other*** **Preferred** NSAID (to ***equal a total of at least two (2) Preferred***). ***(Example: member who failed ibuprofen or naproxen will still need to try oral diclofenac for approval of Flector®.)***
- **Please list drugs tried and failed:**

1. _____ 2. _____

3. _____ 4. _____

Pennsaid™, Vopac™ MDS, and Xrylix™ Kit - ***can only be approved for the FDA-approved indication of osteoarthritis of the knee.***

Solaraze® 3% and diclofenac sodium 3%: ***only approved for the topical treatment of actinic keratosis.***

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**