OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST FORM*

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. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Drug Requested: **Abilify Mycite®** (aripiprazole) **(Non-Preferred)**

DRUG INFORMATION: Complete **all** information below or authorization will be delayed

Drug Form/Strength: ______________________ **Quantity per Day:** ______________

Dosing Schedule: ______________________ **Length of Therapy:** ______________

Diagnosis: ______________________ **ICD Code, if applicable:** ______________

CLINICAL CRITERIA. Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

INITIAL AUTHORIZATION APPROVAL – Three (3) months

- ❑ Member must be ≥ 18 years of age

AND

- ❑ Have tolerability to oral aripiprazole with suboptimal effects (as assessed by prescriber) that may be due to adherence problems

AND

- ❑ Have a smart phone compatible with the device

AND

- ❑ Give consent to a healthcare provider and caregiver (if applicable) to monitor the portal

AND

- ❑ There is a documented intervention by prescriber if nonadherence is detected.

RENEWAL AUTHORIZATION APPROVAL – Every Three (3) Months Reevaluate

- **Member must:**

- ❑ Continue to meet initial criteria;

AND

- ❑ Have prescriber attestation that member benefited from therapy;

(Continued on next page)

AND

- ❑ Have prescriber attestation that there is a continued need for device (e.g., continued suboptimal effects and/or compliance);

AND

- ❑ Have a healthcare provider and caregiver (if applicable) agree to continue to monitor device;

AND

- ❑ Not have worsened target symptoms;

AND

- ❑ Not have had any treatment-limited adverse effects (e.g., hypersensitivity, suicidality, neuroleptic malignant syndrome, tardive dyskinesia, metabolic changes, pathological gambling and other compulsive behaviors, orthostatic hypotension, falls, seizures, cognitive and motor impairment, dysphagia, disruption in body temperature regulation, and leukopenia, neutropenia, and agranulocytosis);

AND

- ❑ Have a healthcare provider state reason why the patient cannot use long-acting injectable atypical antipsychotics if there is continued nonadherence.

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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 #: ____

UPDATED/REVISED: 6/18/2019