OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 (select one from below): Atypical Antipsychotics (Non-Preferred)			
❑ **Abilify®** (aripiprazole) tab and IM	❑ aripiprazole ODT	❑ **Clozaril®** (clozapine)	❑ clozapine ODT
❑ **Fanapt®** (iloperidone) tab & titration pk	❑ **FazaClo®** (clozapine)	❑ **Geodon®** (ziprasidone HCl)	❑ **Invega®** (paliperidone)
❑ olanzapine IM	❑ paliperidone ER	❑ **Rexulti®** (brexpiprazole)	❑ **Risperdal®** (risperidone)
❑ **Saphris® SL** (asenapine)	❑ **Seroquel IR®** (quetiapine)	❑ **Seroquel XR®** (quetiapine)	❑ **Symbyax®** (olanzapine & fluoxetine hydrochloride)
❑ **Versacloz™** (clozapine, USP)	❑ **Vraylar™** (cariprazine)	❑ **Zyprexa®** (olanzapine)	

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Name/Form/Strength: _____

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

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

- **If diagnosis is any type of depressive disorder, please list current antidepressant therapy:**

_____

_____

(Continue on next page; Signature MUST be included with this request.)

(Signature MUST to be included with this request)

CLINICAL CRITERIA: To qualify, boxes **must** be checked to ensure authorization process will **NOT** be delayed.		
❑ Patient has tried and failed **at least 30 days** of therapy with **two (2)** of the following:		
❑ aripiprazole soln & tab	❑ clozapine tab	❑ Geodon® IM (ziprasidone HCl)
❑ Latuda® (lurasidone)	❑ olanzapine ODT/tab	❑ olanzapine/fluoxetine
❑ quetiapine tab	❑ quetiapine fumarate ER	❑ risperidone ODT/soln/tab
❑ ziprasidone capsule		

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: ~~3/21/2018;~~ **8/16/2018**;