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 the authorization process.**

Long-Acting Beta Adrenergics (LABAs) for Children

DRUG REQUESTED: Each drug listed below will require a PA for ages less than the FDA/PI indicated age. Check applicable box below that applies and complete the information. If incomplete, authorization process will be delayed.

Brand Name	Age where PA is required	FDA Indications
❑ Advair® Diskus 250/50, & 500/50	Children < 12 years	Asthma & COPD
❑ Advair® HFA	Children < 12 years	Asthma & COPD
❑ Advair® Diskus 100/50	Children < 4 years	Asthma & COPD
❑ Airduo™ Respiclick®	Children < 12 years	Asthma only
❑ Anoro™ Ellipta™	Children & Adolescents < 18 years	COPD only
❑ Arcapta® Neohaler	Children & Adolescents < 18 years	COPD only
❑ Bevespi Aerosphere™	Children & Adolescents < 18 years	COPD only
❑ Breo Ellipta®	Children & Adolescents < 18 years	Asthma & COPD
❑ Brovana®	Children & Adolescents < 18 years	COPD only
❑ Dulera®	Children < 12 years	Asthma only
❑ fluticasone/salmeterol pow	Children < 12 years	Asthma only
❑ Foradil® Aerolizer	Children < 5 years	Asthma & COPD
❑ Perforomist®	Children & Adolescents < 18 years	COPD only
❑ Serevent® Diskus*	Children < 4 years	Asthma & COPD
❑ Stiolto™ Respimat®	Children < 18 years	COPD only
❑ Striverdi® Respimat®	Children < 18 years	COPD only
❑ Symbicort®	Children < 12 years	Asthma & COPD

(continued on next page)

DRUG INFORMATON: Complete the information below or authorization will be delayed.

Drug Name/Form/Strength: _____

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

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

LENGTH OF AUTHORIZATON: 3 months

CLINICAL CRITERIA: The following criteria **MUST** be met to qualify to ensure authorization will **NOT** be delayed.

- Trial and failure of at least **two (2) Preferred** drugs in the category? ❑ Yes ❑ No

  If ***No,*** explain rationale why the **Preferred** drugs will not provide adequate benefit. _____

  _____

  _____

MEDICAL NECESSITY: Provide clinical documentation why the medication requested is to be used for less than the FDA/PI indicated age**.**

*****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: ~~7/10/2017; 8/31/2017;~~ **8/24/2018**