OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY 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 forms will delay the authorization process**.

Drug Requested: Adderall XR® (amphetamine, dextroamphetamine mixed salts **(Brand, Preferred)**

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

Drug Form/Strength: ____

Dosing Schedule/Frequency: ____

Quantity Requested: ______________________________ **Total Daily Dose:** ______________

Diagnosis: ______________________________________ ***ICD Code, if applicable*:** ____________

CLINICAL CRITERIA: Complete the information below.

- If a trial and failure of a **Preferred** drug occurs and the physician requests Adderall XR® or amphetamine salts combo XR, **BRAND** Adderall XR® is **PREFERRED** over the generic.

List pharmaceutical agents attempted and outcome: ______________________________________

____

____

MEDICAL NECESSITY: Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this patient.

____

____

****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 #: ______________________________ Member Date of Birth: ____________________

Prescriber Name: ____

Prescriber Signature: ______________________________ Date: ____________________

Office Contact Name: ____

Phone Number: ______________________________ Fax Number: ____________________

DEA OR NPI #: ____

REVISED/UPDATED: 7/6/2017; 8/28/2017; **8/15/2018**