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 (Choose one from below):

❑ **Emverm**® (mebendazole)	❑ **Albenza**® (albendazole)

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

Drug Name/Form/Strength: _____

Requested Dose: _____ **Length of Therapy**: _____

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

{Trial of pyrantel pamoate **required** for **Pinworm** and **Hookworm** infections.}

Listed below are the Center for Disease Control recommendations for treatment of Pinworm and Hookworm:

CDC Recommendations for Pinworm Treatment	**Dosage for Adults and Children**
Pyrantel pamoate	11mg/kg base PO once; repeat in 2 weeks
Mebendazole	100mg PO once; repeat in 2 weeks
Albendazole	For children ≥20kg: 400mg PO once; repeat in 2 weeks For children <20kg: 200mg PO once; repeat in 2 weeks
CDC Recommendations for Hookworm Treatment	**Dosage for Adults and Children**
Pyrantel pamoate	11mg/kg (up to a maximum of 1gm) PO daily for 3 days
Mebendazole	100mg PO BID for 3 days or 500mg orally once
Albendazole	400mg PO once

CLINICAL CRITERIA: All boxes **MUST** be checked to qualify or authorization process will be delayed. **{Indication, length of therapy, and requested dose must be noted above.}**

- ❑ For ***Pinworm*** infection: Patient has tried and failed **at least 2 doses** of a pyrantel pamoate product - initial dose followed by second dose 2 weeks later. Paid pharmacy claim for a pyrantel pamoate product **MUST** be noted in patient's pharmacy profile.

OR

- ❑ For **Hookworm** infection: Patient has tried and failed **at least 3 consecutive daily doses** of a pyrantel pamoate product. Paid pharmacy claim for a pyrantel pamoate product **MUST** be noted in patient's pharmacy profile.

(Continued on next page; signature **MUST** be attached to this request.)

(Signature page **MUST** be attached to this request.)

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:** ~~8/26/2017;~~ **8/15/2018**