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 forms will delay the authorization process.**

Drug Requested: ANTIEMETIC/ANTIVERTIGO

DRUG INFORMATION: Check **all** that apply and complete information below the drug lists. If incomplete, authorization process will be delayed.

PREFERRED Medications

❑ dronabinol – **(Requires PA)**	❑ ondansetron ODT/tab **(NO PA required)**	❑ meclizine **(NO PA required)**
❑ metoclopramide tab/sol – (**NO PA required)**	❑ ondansetron tab & ODT **(NO PA required)**	❑ prochlorperazine tab/syrup **(NO PA required)**
❑ promethazine **(NO PA required)**		

All Non-Preferred Medications (requires PA)

❑ Anzemet®	❑ aprepitant capsule/pack	❑ Akynzeo®	❑ Antivert®
❑ Compazine® sup/tab	❑ Compro®	❑ Cesamet®	❑ Diclegis®
❑ dimenhydrinate	❑ Emend® Bi Pak	❑ Emend® cap	❑ Emend® Tri-fold pack
❑ Emend® susp	❑ granisetron	❑ hydroxyzine	❑ Kytril®
❑ Marinol®	❑ Metozolv® ODT	❑ metoclopramide ODT	❑ ondansetron soln
❑ Phenergan®	❑ prochlorperazine sup	❑ promethazine	❑ Reglan®
❑ Sancuso® patch	❑ Tigan®	❑ Transderm-Scop®	❑ trimethobenzamide
❑ Varubi®	❑ Zofran® ODT/soln/tab	❑ Zuplenz® film	❑ Cinvanti™ IV

Drug Name/Form: _____ **Strength:** _____

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

(continued on next page)

DIAGNOSIS AND CLINICAL CRITERIA: Check applicable box(es) below to ensure authorization process will **NOT** be delayed.

1. Diagnosis of severe, chemotherapy induced nausea and vomiting ❑ Yes ❑ No
2. If diagnosis is AIDs-related wasting, member has tried and failed megestrol acetate oral suspension **OR** has a contraindication, intolerance, drug-drug interaction. ❑ Yes ❑ No ❑ N/A
3. Nausea or vomiting related to radiation therapy, moderate-to-highly emetogenic chemotherapy, or post-operative nausea and vomiting. ❑ Yes ❑ No
4. Member has tried and failed therapeutic does of, or has adverse effects or contraindications to two (2) different conventional antiemetics (e.g., promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone, etc.) ❑ Yes ❑ No
5. Hyperemesis (pregnancy-related nausea/vomiting) ❑ Yes ❑ No

Provide clinical evidence that the **Preferred** agent(s) **will not** provide adequate benefit **and** list pharmaceutical agents attempted and outcome: _____

_____

_____

_____

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: ~~6/30/2017~~; ~~7/17/2017~~; ~~8/31/2017~~; ~~3/22/2018~~; ~~7/1/2018~~; **8/16/2018**;