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 a Prior Authorization)		
❑ dronabinol **(Requires PA)**	❑ ondansetron ODT/tab **(NO PA required)**	❑ meclizine **(NO PA required)**
❑ metoclopramide tab/sol(**NO PA required)**	❑ prochlorperazine tab/syrup **(NO PA required)**	❑ promethazine **(NO PA required in members over 2 yrs of age)**

All Non-Preferred Medications require Prior Authorization			
❑ Akynzeo®	❑ Antivert®	❑ Anzemet®	❑ aprepitant capsule/pack
❑ Bonjesta®	❑ Cesamet®	❑ Compazine® sup/tab	❑ Compro®
❑ Cinvanti™ IV	❑ Diclegis®	❑ dimenhydrinate	❑ Emend® Bi Pak
❑ Emend® cap	❑ Emend® Tri-fold pack	❑ Emend® susp	❑ granisetron
❑ hydroxyzine	❑ Kytril®	❑ Marinol®	❑ metoclopramide ODT
❑ Metozolv® ODT	❑ ondansetron soln	❑ Phenergan®	❑ promethazine 50mg Supp
❑ prochlorperazine sup	❑ Reglan®	❑ Sancuso® patch	❑ Syndros™
❑ Tigan®	❑ Transderm-Scop®	❑ trimethobenzamide	❑ Varubi® IV, tab
❑ Vistaril®	❑ Zofran® ODT/soln/tab	❑ Zuplenz® film	

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
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. Member has hyperemesis (pregnancy-related nausea/vomiting)? ❑ Yes ❑ No
6. 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;~~ **10/23/2018**