

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: **Oral Antifungals (Non-Preferred)**

DRUG INFORMATION: Check below all that apply. Information must be completed to ensure authorization will NOT be delayed.				
All Non-Preferred Medications (requires PA)				
<input type="checkbox"/> Ancobon [®]	<input type="checkbox"/> clotrimazole (mucous mem)	<input type="checkbox"/> Cresemba [®]	<input type="checkbox"/> Diflucan [®] tab/susp	<input type="checkbox"/> flucytosine
<input type="checkbox"/> griseofulvin tab	<input type="checkbox"/> Itraconazole	<input type="checkbox"/> ketoconazole	<input type="checkbox"/> Lamisil [®] tab	<input type="checkbox"/> Lamisil [®] granules
<input type="checkbox"/> Noxafil [®]	<input type="checkbox"/> Onmel [®]	<input type="checkbox"/> Sporanox [®] cap/sol	<input type="checkbox"/> Terbinex [™] kit	<input type="checkbox"/> Vfend [®] tab/susp
<input type="checkbox"/> voriconazole tab	<input type="checkbox"/> voriconazole powder for susp			

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

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

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

DIAGNOSIS AND MEDICAL INFORMATION: Complete **all** information below or authorization process will be delayed.

1. Has the Recipient tried and failed any of the **Preferred Oral** Antifungals? Yes No
Check below **ALL** that apply:

<input type="checkbox"/> fluconazole tab/susp	<input type="checkbox"/> nystatin tab	<input type="checkbox"/> Griseofulvin [®] susp
<input type="checkbox"/> nystatin susp	<input type="checkbox"/> terbinafine	

Submit ALL supporting documentation of drug regimen and therapeutic failure

2. Does the Recipient have any contraindications or intolerances to any of the **Preferred** agents listed in question 1? Yes No

If **Yes**, document the specialty: _____

3. Does the Recipient have a diagnosis for which none of the **Preferred Oral** Antifungals are indicated or widely medically-accepted? Yes No

Check below **ALL** that apply or indicate diagnosis:

<input type="checkbox"/> aspergillosis	<input type="checkbox"/> blastomycosis	<input type="checkbox"/> other _____
<input type="checkbox"/> mucormycosis	<input type="checkbox"/> histoplasmosis	

Submit documentation of diagnosis and planned duration of treatment.

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: 6/29/2017; 8/28/2017; 8/16/2018; 11/10/2018; 11/13/2018; 12/11/2018