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 Cephalosporins

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

Drug Name/Form/Strength: _____

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

Length of Authorization: Date of Service; no refills

Check applicable box (es) below. If not checked, authorization process will be delayed**.**

PREFERRED		
❑ cefaclor cap	❑ cefprozil cap/susp	❑ cefuroxime tab
❑ cefdinir cap/susp	❑ cefixime suspension	
Non-Preferred		
❑ cefaclor ER	❑ Cedax® cap/susp	❑ cefditoren pivoxil
❑ cefaclor susp	❑ ceftibuten	❑ cefpodoxime proxetil cap/susp
❑ Ceftin® tab/susp	❑ Suprax® chewable tab/cap/susp	❑ Spectracef®

CLINICAL CRITERIA: Check applicable box below that apply or authorization process will be delayed.

❑ Infection caused by an organism resistant to preferred drugs; ❑ Yes ❑ No

OR

❑ Therapeutic failure to no less than a three-day trial of **one preferred cephalosporin**; ❑ Yes ❑ No

OR

❑ Member is completing a course of therapy with a non-preferred drug which was initiated in the hospital. ❑ Yes ❑ No

MEDICAL NECESSITY: Provide clinical evidence that the preferred agent(s) will **not** provide adequate benefit:

_____

_____

(continued on next page; Signature MUST be provided with this request)

(Signature page MUST be included with 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: ~~6/29/2017; 8/28/2017;~~ **8/17/2018**