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: **Colcrys™** (colchicine, USP) **(Non-Preferred)**

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

Drug Form: _____ **Strength**: _____

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

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

Length of Authorization: **1 year**

CLINICAL CRITERIA: Check the box(es) below that apply to ensure authorization will **NOT** be delayed.

- ❑ Patient has diagnosis of Familial Mediterranean Fever;

  OR

- ❑ Acute Gout Flare:
  - ❑ Trial and failure of one of the following:
    - ❑ NSAID or corticosteroid

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:** ~~6/30/2017; 8/28/2017;~~ **8/17/2018**