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**.

Pancreatic Enzymes

DRUG REQUESTED: Check box(es) below that apply to ensure authorization will **NOT** be delayed.

PREFERRED Pancrelipase	Non-Preferred Pancrelipase
❑ Creon®	❑ Pancreaze®
❑ Zenpep®	❑ Pertzye®
❑ pancrelipase (generic)	❑ Ultresa®
	❑ Viokace®

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

Drug Name/Form/Strength: ____________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________________

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

Length of Authorization: 1 year

CLINICAL CRITERIA: Check box for applicable diagnosis or authorization process will be delayed.

- Patient diagnosed with pancreatic insufficiency due to: ***(select one below)***

  ❑ Cystic Fibrosis **OR** ❑ chronic pancreatitis **OR** ❑ pancreatectomy

For ***ALL*** drugs – if member has a diagnosis of Cystic Fibrosis, there is ***no*** requirement to try and fail a preferred

If patient has a feeding tube, then 2 different pancreatic enzymes can be approved for use together.

*****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**