

**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 form will delay authorization process.**

**Drug Requested (select one below):**

<input type="checkbox"/> <b>Doryx®</b> (doxycycline hyclate DR)	<input type="checkbox"/> <b>doxycycline hyclate DR</b>	<input type="checkbox"/> <b>Acticlate®</b> (doxycycline hyclate)
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**DRUG INFORMATION:** Complete information below or authorization process will be delayed.

**Drug Name/Form/Strength:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_ **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code, if applicable:** \_\_\_\_\_

**CLINICAL CRITERIA:** **ALL** boxes **must** be checked to qualify or authorization process will be delayed.

Patient has tried and failed at least **30 days** of therapy with:

Topical clindamycin or erythromycin

**AND**

Generic immediate release doxycycline

**\*\*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 #: \_\_\_\_\_