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: **Edecrin®** (ethacrynic acid)

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

Drug Form/Strength: ____________________

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

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

CLINICAL CRITERIA: Boxes **MUST** be checked below to qualify or authorization process will be delayed. Chart notes **MUST** be attached to this request for verification.

- ❑ Documentation of a sulfa allergy
- ❑ Trial and failure of a loop or thiazide diuretic

*****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:** ~~8/26/2017;~~ **8/18/2018**