

**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 the authorization process.**

**Drug Requested: Enstilar®** (calcipotriene and betamethasone dipropionate) **Foam – (Non-Preferred)**

**DRUG INFORMATION:** Complete the following information or authorization process will be delayed.

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

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

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

**Length of Authorization:** 4 weeks

**CLINICAL CRITERIA:** The following criteria **MUST** be met to ensure authorization will **NOT** be delayed.

Patient has a diagnosis of plaque psoriasis

**AND**

Patient is  $\geq$  18 years

*\*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; 8/29/2017; 8/18/2018