# 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 (check applicable drug below):** | |
|---|---|
| ❑ **Esbriet®** (pirfenidone) | ❑ **Ofev®** (nintedanib) |

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

**Drug Form/Strength/Quantity per Day:** _____

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

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

**CLINICAL CRITERIA:** To receive a **ONE (1) year approval** for the listed drugs, **ALL** appropriate boxes below **must** be checked to qualify or authorization process will be delayed.

- Is medication being prescribed by a pulmonologist? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- Does member have a diagnosis of idiopathic pulmonary fibrosis (IPF)? ❑ Yes ❑ No
- Member's baseline percent predicted forced vital capacity (FVC) is ≥ 50%? ❑ Yes ❑ No
- Have liver function tests been performed? If yes, indicate the date: _____ ❑ Yes ❑ No
- Does member smoke? ❑ Yes ❑ No

**MEDICAL NECESSITY:** Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request.

_____

_____

_____

***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:** ~~12/23/2017;~~ **8/20/2018**