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: Hemangeol™ (propranolol hydrochloride) **(Non-Preferred)**

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

Drug Form/Strength: _____

Dosing Frequency: _____ **Length of Therapy**: _____

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

CLINCIAL CRITERIA: The following criteria **must** be met to ensure authorization will **NOT** be delayed.

- ❑ Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy

  AND

- ❑ Member's age must be between 5 weeks and 5 months

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; 8/30/2017;~~ **8/19/2018**