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. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Hepatitis C Antivirals (PREFERRED)

Drug Requested - Select below the drug that applies:	
❑ **Mavyret™** (glecaprevir/piprentasvir)	❑ **sofosbuvir/velpatasvir**

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

Drug Form/Strength: ____

Dosing Schedule: ______________________ **Length of Therapy**: ________________

Quantity per Day: ______________________ **ICD Code, if applicable:** ______________

Member Age: ______________________

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

DIAGNOSIS: Check box that applies to ensure authorization will **NOT** be delayed.		
❑ **Chronic Hepatitis C**	❑ **Compensated cirrhosis**	❑ **Hepatocellular carcinoma**
❑ **Status post-liver transplant**	❑ **Decompensated cirrhosis (Child Pugh score class B or C)**	

HCV Genotype: Check box below that applies.					
❑ **1a** (polymorphism) **(Submit test results)**		❑ **1a** with polymorphism **(Submit test results)**			
❑ **1b**	❑ **2**	❑ **3**	❑ **4**	❑ **5**	❑ **6**

Choose One below:

❑ Treatment initiation ❑ Continuation of therapy, current week: ____________________

(Continued on next page)

ADHERENCE: Box below **MUST** be checked to ensure authorization will **NOT** be delayed.

1. Has prescriber assessed member for adherence with medical and pharmacological treatment?
❑ Yes ❑ No

I attest that all information provided is accurate: ❑ Yes ❑ No

(By signing below, the Physician confirms the above information is accurate and verifiable by member records.)

____ ______________
(Prescriber Signature Required) **(Date)**

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.

Member Name: ____
Member Optima #: ______________________________ Date of Birth: ________________
Prescriber Name: ____
Office Contact Name: ____
Phone Number: ______________________________ Fax Number: ________________
DEA OR NPI #: ____

***REVISED/UPDATED:** ~~12/27/2017; 6/15/2018; 8/27/2018; 6/14/2019;~~ **8/13/2019**;