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: Kapvay® SR 12H (clonidine hydrochloride extended-release)

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

Drug Form/Strength: _____

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

Quantity Requested: _____ **Total Daily Dose:** _____

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

CLINICAL CRITERIA: The following criteria **MUST** be me or authorization process will be affected.

- Trial and failure of at least **one (1) Preferred** drug

List medications attempted and the outcome: _____

_____

_____

MEDICAL NECESSITY: Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this patient.

_____

_____

_____

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: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~7/6/2017~~; ~~8/31/2017~~; ~~10/12/2017~~; **8/23/2018**