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: **Macrolides & Ketolides, Oral (Non-Preferred)**

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

Drug Form: ________________________________ **Strength**: ________________________

Dosing Schedule: ______________________________ **Length of Therapy**: ____________________

Diagnosis: ____________________________________ **ICD Code, if applicable:** ______________

CLINICAL CRITERIA: Check applicable box below that applies to ensure authorization will **NOT** be delayed.

- ❑ Infection caused by an organism resistant to preferred drugs

  OR

- ❑ A therapeutic failure to no less than a **three-day trial of one preferred drug within the same class**;

  OR

- ❑ Patient is completing a course of therapy with a non-preferred drug which was initiated in the hospital.

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 #: ______________________________________ Fax #: ___________________________

DEA OR NPI #: ____

***REVISED/UPDATED:** 6/29/2017; 8/31/2017; **8/27/2018**