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.

Macrolides & Ketolides (Oral)

Drug Requested: Check box below that applies.

<table>
<thead>
<tr>
<th>PREFERRED</th>
<th>NON-PREFERRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>azithromycin pack/susp/tab</td>
<td>clarithromycin tab/susp</td>
</tr>
<tr>
<td>✗ E.E.S.® 200 susp</td>
<td>erythromycin base cap DR</td>
</tr>
<tr>
<td></td>
<td>erythromycin stearate</td>
</tr>
<tr>
<td>Biaxin® tab</td>
<td>clarithromycin ER</td>
</tr>
<tr>
<td>E.E.S.® 400 tab</td>
<td>erythromycin base tab</td>
</tr>
<tr>
<td>erythromycin ethylsuccinate</td>
<td>Ery-tab®</td>
</tr>
<tr>
<td>200 mg susp</td>
<td>erythromycin ethylsuccinate 400 mg tab (generic E.E. S.® 400)</td>
</tr>
<tr>
<td>ZMAX® susp</td>
<td>PCE®</td>
</tr>
<tr>
<td></td>
<td>Zithromax® pac/tab/susp</td>
</tr>
</tbody>
</table>

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

Drug Form: ___________________________ Strength: ___________________________

Dosing Schedule: ___________________________ Length of Therapy: ___________________________

Diagnosis: ___________________________ ICD Code, if applicable: ___________________________

CLINICAL CRITERIA (for Non-Preferred): 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.

- Infection caused by an organism resistant to preferred drugs
  OR
- A therapeutic failure to no less than a three-day trial of ONE (1) PREFERRED drug within the same class;
  OR

(Note continued on next page)
Member is completing a course of therapy with a **non-preferred drug** which was initiated in the hospital.

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

- Treatment of community-acquired pneumonia (of mild to moderate severity)
  
  **AND**

- Infection is caused by **ONE** of the following microorganism:
  - Streptococcus pneumonia **OR**
  - Haemophilus influenza **OR**
  - Moraxella catarrhalis **OR**
  - Chlamyphila pneumonia **OR**
  - Mycoplasma pneumonia

  **AND**

- Therapeutic failure to no less than a **three (3) day trial of ONE (1) Preferred** drug within the same class; **OR**

- Member is completing a course of therapy with a **non-preferred** drug 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 #: ___________________________