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: Mirvaso® (brimonidine)

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

Drug Form/Strength/Quantity per Day: _____

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

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

CLINICAL CRITERIA: To receive a **ONE (1) year approval** for this drug, **ALL** appropriate boxes below **must** be checked to qualify to ensure authorization process will **NOT** be delayed.

Does member meet the following criteria?

- Is member 18 years of age or older? ❑ Yes ❑ No
- Diagnosis of persistent (nontransient) facial erythema due to rosacea? ❑ Yes ❑ No
- Is member currently being treated another topical or oral medication indicated for rosacea? ❑ Yes ❑ No
  - Member must also be receiving treatment with one of the following:
    - Topical antibiotics [e.g. Metrogel® (metronidazole), Cleocin T® (clindamycin)
    - Oral antibiotics [e.g. doxycycline, minocycline, tetracycline, metronidazole]
    - Topical azelaic acid [Finacea®, Azelex®]

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request.

_____

_____

_____

(Continued on next page; signature MUST be attached to this request.)

(Signature page MUST be included with this request.)

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: ~~12/23/2017;~~ **8/27/2018**