OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY STEP-EDIT AUTHORIZATION 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 form will delay authorization process**.

Drug Requested: **MuGard**® (oral mucoadhesive)

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

Drug Form/Strength: ____

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

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

RECOMMENDED USE: **4-6 times a day for management of oral mucositis/stomatitis.**

MAX dose of MuGard: **1 bottle (8 fluid ounces/240 mL) per fill**

CLINICAL CRITERIA: **ALL** boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed. **ALL** chart notes and lab results **MUST** be attached to request.

- ❑ Has the member tried and failed (**paid claims will be documented**):
  - ❑ Oramagic Plus for at least 30 days?

    AND

  - ❑ Magic Mouthwash for at least 30 days?

Medication being provided by a Specialty Pharmacy - Sentara Norfolk General CM Pharmacy

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:** ~~8/26/2017;~~ **8/27/2018**