OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST FORM*

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. All questions must be answered.**

Drug Requested: **Nuplazid™** (pimavanserin) **(Non-Preferred)**

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____ **Quantity per Day:** _____

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

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

Quantity Limit: 2 per day

CLINICAL CRITERIA: The following criteria **MUST** be met to ensure authorization will **NOT** be delayed.

- Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis
- Patient tried and failed at least **two (2) Preferred** medications? ❑ Yes ❑ No

  If **YES,** please list drugs and outcome: _____

  _____

  _____

MEDICAL NECESSITY: If requesting a **Non-Preferred** drug, please document why a **PREFERRED** drug **cannot** be used. If more space is needed, please attach a separate document with member's information.

_____

_____

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 #: _____

UPDATED/REVISED: ~~7/6/2017; 8/31/2017;~~ **8/28/2018**