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: ❑ **Onfi®** (clobazam) **(Non-Preferred)**

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

Drug form/Strength: _____

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

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

CLINCIAL CRITERIA: The following clinical criteria **must** be met to ensure authorization process will **NOT** be delayed.

- ❑ Patient is at least two years of age or older

AND

- ❑ Patient must have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS);

AND

- ❑ Using as adjunctive therapy with other anticonvulsants;

AND

- ❑ Prescribing physician should submit documentation of an insufficient response to another medication used for LGS

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:** ~~6/30/2017; 8/31/2017;~~ **8/28/2018**