

**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 form will delay authorization process.**

**Drug Requested:**            **Oravig®** (miconazole)

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

**Drug Form/Strength:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_      **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_      **ICD Code, if applicable:** \_\_\_\_\_

**CLINICAL CRITERIA:** Criteria below **must** be checked to qualify to ensure authorization will **NOT** be delayed.

- Patient has tried and failed:
  - clotrimazole
- OR**
- fluconazole

***\*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 #: \_\_\_\_\_