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**.

Platelet Inhibitors (Non-Preferred)

Drug Requested (check applicable box below):

Preferred Drugs		**Non-Preferred Drugs**	
❑ Brilinta®	❑ clopidogrel	❑ Aggrenox®	❑ ASA/dipyridamole
❑ dipyridamole	❑ Effient®	❑ Durlaza® ER	❑ Persantine®
❑ ticlopidine HCL		❑ Plavix®	❑ Yosprala® tab
		❑ Zontivity®	

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

Drug Form: _____ **Strength**: _____

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

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

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

- Aspirin is covered without a Prior Authorization.
- Trial and failure of two (2) **PREFERRED** drugs. **Please list drugs tried and failed**.

_____

_____

_____

MEDICAL NECESSITY: Provide clinical reason below why aspirin cannot be used**.**

_____

_____

_____

_____

(Continued on next page; signature page MUST be included with this request.)

(Signature page MUST be attached to 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:** ~~7/6/2017;~~ ~~8/31/2017;~~ **8/29/2018**