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: Proton Pump Inhibitors (PPI) Drugs (Non-Preferred)

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

Drug Name/Form/Strength: _____

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

Length of Authorization: 12 weeks; unless patient meets an exception, then 1 year

CLINICAL CRITERIA: The information below **MUST** be completed to ensure authorization will **NOT** be delayed.

❑ **Initial Request**	❑ **Renewal Request**

NOTE: PDL Criteria must be met first before a non-preferred PPI may be approved.

- **Initial requests** - may be authorized for **12 weeks only.**
- **Renewal requests** - may be allowed for **1 year** if one of the following exceptions has been met:
  - Patient under the care of a Gastroenterologist **OR** patient has a diagnosis of **ACTIVE** GI Bleed, Erosive Esophagitis, or Zollinger-Ellison Syndrome.

- Has the patient had a therapeutic failure of no less than a **3-month trial of at least TWO Preferred** PPIs*?* ❑ Yes ❑ No

  If ***Yes***, list medications.

  - **Drug 1**: _____Strength: _____ Start Date: _____
  - **Drug 2:** _____Strength: _____ Start Date: _____
  - **Drug 3:** _____Strength: _____ Start Date: _____

  If ***No***, document compelling details. _____

- Has this patient seen a Gastroenterologist? ❑ Yes ❑ No

  If ***Yes***, document name: _____

- Does this patient have one of the following conditions?
  - ACTIVE GI Bleed ❑ Yes ❑ No
  - Erosive Esophagitis ❑ Yes ❑ No
  - Zollinger-Ellison Syndrome ❑ Yes ❑ No

(continued on next page)

MEDICAL NECESSITY: Provide clinical evidence that the **PREFERRED** agent(s) will not provide adequate benefit.

_____

_____

_____

_____

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 #: _____

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