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)**

PREFERRED PPIs (No Prior Authorization required for short-term use; less than 90 days.)			
❑ **Omeprazole OTC and RX**		❑ **Pantoprazole**	
Non-Preferred PPIs			
❑ Aciphex® DR tab/sprinkle	❑ Dexilant®	❑ esomeprazole magnesium	❑ esomeprazole strontium
❑ lansoprazole cap	❑ Nexium®	❑ omeprazole/sodium bicarbonate	❑ Prevacid® RX, OTC, & Solutab
❑ rabeprazole DR tab	❑ Prilosec® RX & Susp	❑ Protonix®	❑ Zegerid® cap / OTC/ susp packet

All PPIs (Preferred and Non-Preferred) after 90 days' utilization MUST meet the clinical prior authorization criteria for continued use.

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

Drug Name/Form: _____

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

Quantity per Day: _____

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.

1. Request type: ❑ **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** – for both **preferred** and **non-preferred** PPI usage for greater than 3 months may be allowed for 1 year **ONLY** if one of the following exceptions has been met:

- Patient is under the care of a Gastroenterologist **OR** patient has a diagnosis of **ACTIVE** GI Bleed, Erosive Esophagitis, Gastroesophageal Reflux Disease, Pathological Hypersecretory Syndrome, Unhealed Gastric, Duodenal or Peptic Ulcer, Barrett's Esophagus or Zollinger-Ellison Syndrome.

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

   a. If **YES**, list medications.

   Drug 1: _____Strength: _____ Start Date: _____

   Drug 2: _____Strength: _____ Start Date: _____

   Drug 3: _____Strength: _____ Start Date: _____

   b. If **NO**, document compelling details. _____

   _____

   _____

3. Has this patient seen a Gastroenterologist? ❑ Yes ❑ No

   If **YES**, document name: _____

4. Does this patient have one of the following conditions?

   a. GI Bleeds ❑ Yes ❑ No

   b. Zollinger-Ellison Syndrome ❑ Yes ❑ No

   c. Gastroesophageal Reflux Disease ❑ Yes ❑ No

   d. Pathological Hypersecretory Syndrome ❑ Yes ❑ No

   e. Unhealed Gastric, Duodenal or Peptic Ulcer ❑ Yes ❑ No

   f. Barrett's Esophagus ❑ Yes ❑ No

   g. Erosive Esophagitis ❑ Yes ❑ No

5. **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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