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**.

Quinolones (Non-Preferred)

Drug Requested (check applicable drug below):		
Non-Preferred		
❑ Cipro® IR & XR & susp	❑ ofloxacin	❑ levofloxacin
❑ ciprofloxacin ER	❑ Avelox®	❑ moxifloxacin
❑ Noroxin®	❑ Levaquin® tab/susp	

Drug Information: Complete information below or authorization will be delayed.

Drug Name/Form/Strength: _____

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

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

Length of Authorization: ONE TIME ONLY; no refills

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

❑ Infection caused by an organism resistant to ciprofloxacin and levofloxacin? ❑ Yes ❑ No

OR

❑ Therapeutic failure to no less than a **three-day trial of ciprofloxacin OR levofloxacin**? ❑ Yes ❑ No

OR

❑ Member is completing a course of therapy with a non-preferred drug which was initiated in the hospital? ❑ Yes ❑ No

(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: ~~6/29/2017; 8/31/2017;~~ **8/29/2018**