

**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: **Ravicti®** (glycerol phenylbutyrate)

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

Drug Name/Form/Strength: _____

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

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

Quantity per Day: _____

CLINICAL CRITERIA: To receive a **SIX (6) month approval** of this drug, **ALL** boxes **MUST** be checked to ensure authorization will be delayed.

- Prescriber is a Pediatric Endocrinologist? Yes No
- Is member 2 years of age or older? Yes No
- Has member been diagnosed with a urea cycle disorder? Yes No
- Has member been on a dietary protein restriction and/or an amino acid supplementation? Yes No
- Does member have a diagnosis of acute hyperammonemia? Yes No
- Has a baseline dermatologic evaluation been completed? Yes No

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: 12/23/2017 8/29/2018