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 (select one from below):	
❑ **Caphosol®** (supersaturated calcium phosphate rinse)	❑ **SalivaMax™** (supersaturated calcium phosphate rinse)
❑ **NeutraSal®** (supersaturated calcium phosphate rinse)	❑ **Salivate Rx** (supersaturated calcium phosphate rinse)
❑ **Aquoral®** (oxidized glycerol triesters)	

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

Drug Name/Form/Strength: _____

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

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

****Note: If approved, a maximum of 120 unit doses per 30 days for supersaturated calcium phosphate rinses or 1 unit (40mL) of Aquoral® per 30 days will be authorized****

CLINICAL CRITERIA: Check below **ALL** that apply. Boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed**.**

For Mucositis Indication, check all that apply: (two boxes **must** be checked)

❑ Trial and failure of Magic Mouthwash for **30 days** (**must** be verified by pharmacy paid claims)

AND

❑ Trial and failure of lidocaine 2% viscous solution for **30 days** (**must** be verified by pharmacy paid claims)

OR

❑ Trial and failure of Mouth Kote® solution for **30 days** (**must** be verified by pharmacy paid claims)

For Xerostomia or Hyposalivation Indications, check all that apply: (One box **must** be checked)

❑ Trial and failure of Mouth Kote® solution for **30 days (must be verified by pharmacy paid claims)**

OR

❑ Trial and failure of Biotene Dry Mouth Moisturizing Spray, Biotene Dry Mouth Oral Rinse or Biotene Moisturizing Oral Rinse for **30 days (must be verified by pharmacy paid claims for MEDICAID members)**

(Continued on next page; signature page MUST be attached to the 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:** ~~8/26/2017;~~ **8/29/2018**