

**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 the authorization process.**

Drug Requested: Soma® (carisoprodol)/carisoprodol products) (Non-Preferred)

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: _____ **Quantity Limit** – 4 tablets per day

Length of Authorization: 1 month (Renewal requests will **NOT** be granted for **6 months** following last day of previous course of therapy.)

Initial Request

Renewal Request

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

- Is the patient 16 years of age or older? Yes No
- Does the patient have an **ACUTE**, painful musculoskeletal condition? Yes No

Please indicate diagnosis: _____

List pharmaceutical agents attempted and outcome:

(Continued on next page; signature page **MUST** be included with this request.)

(Signature page **MUST** be included.)

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: 6/30/2017; 8/31/2017; 8/30/2018