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: **Topical Antifungals (Non-Preferred)**

DRUG INFORMATION: Complete the 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 AND DIAGNOSIS: –Answer **ALL** questions to facilitate processing or authorization may be delayed.

Topical Onychomycosis Agents

(to receive a ONE (1) year approval for these drugs, please complete the questions below.)

Does the patient meet the following criteria?

- Diagnosis of onychomycosis? ❑ Yes ❑ No
- Diagnosis of athlete's foot (tinea pedis) or ringworm (tinea cruris, tinea corporis) ❑ Yes ❑ No
- Is the patient 18 years of age or older? ❑ Yes ❑ No
- Penlac®, CNL-8™, Jublia®: must have failure of an adequate trial of 1 oral alternative: ❑ Yes ❑ No
  - **terbinafine** (6 weeks for fingernail infections; 1 week for toenail infections);
  - **fluconazole** (6 months);
  - **itraconazole** (60 days for fingernail infections; 90 days for toenail)
- **Luzu®**: must have failure of an adequate trial of **two (2) preferred** topical antifungal medications, ❑ Yes ❑ No

  OR

  Allergy or contraindication to oral terbinafine, fluconazole or itraconazole? ❑ Yes ❑ No

MEDICAL NECESSITY: Provide clinical evidence that supports the use of the requested medication.

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(Continued on next page; signature page MUST be attached to this request.)

(Signature page MUST be included with 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: 6/320/2017; 9/1/2017; **8/31/2018**;