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**.

Topical Immunomodulators

Drug Requested (select one from below)**:**	
❑ **Zyclara**® (imiquimod) **2.5% Pump**	❑ **Veregen**® (sinecatechins) **Ointment**
❑ **Zyclara**® (imiquimod) **3.75% Packets/Pump**	❑ **Solaraze**® (diclofenac) **3% Gel**

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

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: **ALL** boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed..

For Actinic Keratosis:

(Both boxes must be checked):

- ❑ Patient has a diagnosis of actinic keratosis
- ❑ Requested product:
  - ❑ Zyclara® 2.5% Pump
  - ❑ Zyclara® 3.75% Packets/Pump
  - ❑ Solaraze® 3% Gel

For External Genital and Perianal Warts/Condyloma Acuminata:

(Two boxes must be checked)

- ❑ Patient has a diagnosis of external genital and/or perianal warts/condylomata acuminata

AND

- ❑ Patient has a documented trial and inadequate response or clinically significant adverse reaction to generic Aldara™ 5% cream **(submit chart notes)**

OR

- ❑ Patient has a documented trial and inadequate response or clinically significant adverse reaction to topical podofilox **(submit chart notes)**

(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:** ~~8/27/2017;~~ **8/31/2018**