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: Topical Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) (Non-Preferred)	
Preferred Drugs	**Non-Preferred Drugs**
❑ **Voltaren® 1% gel** (diclofenac sodium gel)	❑ diclofenac sodium 1% gel ❑ diclofenac sodium 3% gel ❑ Flector® patch (**QL**) ❑ Pennsaid® top soln, soln pkt & pump ❑ Solaraze® 3% top gel ❑ Vopac™ MDS ❑ Xrylix™ Kit

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***:* ______________

Length of Authorization: 1 year **Quantity Limit for Flector®** - 30 patches per Rx

CLINICAL CRITERIA: The following criteria **MUST** be met to qualify to ensure authorization will be delayed.

- Approval is based on member failing the oral generic of the desired drug **AND** at least one other **Preferred** NSAID (to equal a total of at least two (2) **Preferred**). **(Example: member who failed ibuprofen or naproxen will still need to try oral diclofenac for approval of Flector®.)**

- **Please list drugs tried and failed:**

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

(continued on the next page)

Pennsaid™, Vopac™ MDS, and Xrylix™ Kit - can **only** be approved for the FDA-approved indication of osteoarthritis of the knee.

Solaraze® 3% and diclofenac sodium 3%: **only** approved for the topical treatment of actinic keratosis.

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:** ~~7/6/2017; 9/1/2017;~~ **8/31/2018**