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: Ulesfia™ Lotion (benzyl alcohol)

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

Drug Form/Strength: ____

Dosing Schedule: ______________________________ **Length of Therapy**: ____________________

Diagnosis: __________________________________ **ICD Code, if applicable**: __________________

Hair Length		Amount of Ulesfia™ Lotion per Application		Recommended Number of Bottles per Application	Total Number of Bottles for Complete Treatment
Short	0-2 inches	4-6 oz.	½ - ¾ bottle	1	2
	2-4 inches	6-8 oz.	¾ - 1 bottle	1	2
Medium	4-8 inches	8-12 oz.	1- 1½ bottles	1.5	3
	8-16 inches	12-24 oz.	1½- 3 bottles	3	6
Long	16-22 inches	24 – 32 oz.	3- 4 bottles	4	8
	Over 22 inches	32-48 oz.	4- 6 bottles	6	12

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

- ❑ Patient has tried and failed a complete course **(administration and re-administration after 7 days)** of **one (1)** formulary OTC Permethrin 1% product **(**Family Care patients must have paid pharmacy claim for a Permethrin 1% product**)**

AND

- ❑ Patient has tried and failed generic Ovide lotion (malathion)

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

(Signature page MUST be included with 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**