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: Urinary Antispasmodics/Bladder Relaxants (check applicable drug(s) below that apply):		
Preferred		
❑ oxybutynin tab/syrup	❑ Toviaz™	❑ VESIcare®
Non-Preferred		
❑ darifenacin ER (generic Enablex®)	❑ Detrol®/Detrol® LA	❑ Ditropan®/Ditropan® XL
❑ Enablex®	❑ flavoxate	❑ Gelnique™ gel/gel Pump
❑ Myrbetriq™	❑ oxybutynin ER	❑ Oxytrol® transdermal
❑ Sanctura® XR	❑ trospium IR/trospium ER	❑ tolterodine IR/tolterodine ER

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

Drug Name/Form/Strength: _____

Dosing Frequency: _____ **Length of Therapy**: _____

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

CLINICAL CRITERIA: The following criteria MUST be met to qualify or authorization process will be delayed.

- Trial and failure of at least **two (2) Preferred** drugs ❑ Yes ❑ No

  List drugs tried and failed: _____

  _____

  _____

- **Oxybutynin ER, Ditropan® XL**: allow PDL exception for children ages 6-18 years with a diagnosis of neurogenic bladder.

MEDICAL NECESSITY: Provide clinical evidence that the **Preferred** drug(s) will not provide adequate benefit:

_____

_____

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

(Signature page MUST be attached to 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: ~~7/6/2017; 9/1/2017;~~ **8/31/2018**;