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 (check drug that applies):

❑ **Xenazine®** (tetrabenazine)	❑ tetrabenazine

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

Drug Name/Form: _____

Drug Strength: _____ **Dosing Schedule:** _____

Length of Therapy: _____ **ICD Code, if applicable**: _____

Diagnosis: _____

CLINICAL CRITERIA: The following criteria **MUST** be met. **ALL** boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

❑ **For Xenazine approval**:

- ❑ Medication is prescribed by or in consultation with a Neurologist; **AND**
- ❑ Patient **MUST** have a diagnosis of chorea associated with Huntington's Disease **(chart notes must document diagnostic criteria and symptoms)**; **AND**
- ❑ Patient must have trial and failure of **at least 30 days** of tetrabenazine **(chart notes must document therapy failure)**

❑ **For tetrabenazine approval:**

- ❑ Medication is prescribed by or in consultation with a Neurologist; **AND**
- ❑ Patient **MUST** have a diagnosis with chorea associated with Huntington's Disease **(chart notes must document diagnostic criteria and symptoms)**

Medication being provided by a Specialty Pharmacy - PropriumRx

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

(Signature page must be attached with form 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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 7/19/18
REVISED/UPDATED: 9/28/2018