

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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: **Absorica®** (isotretinoin)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: ALL appropriate boxes must be checked to qualify or authorization process will be delayed. Chart notes MUST be attached documenting failure or adverse effects.

- Patient is at least 12 years old and has a diagnosis of severe recalcitrant nodular acne
- Patient has failed or experienced a clinically significant adverse effect with one (1) of the following prerequisite medications:

<input type="checkbox"/> Claravis™ (isotretinoin)	<input type="checkbox"/> Amnesteem® (isotretinoin)
<input type="checkbox"/> Zenatane™ (isotretinoin)	<input type="checkbox"/> Myorisan™ (isotretinoin)

****NOTE:**** A single course of therapy for 15 to 20 weeks has been shown to result in complete and prolonged remission of disease in many patients. If a second course of therapy is needed, it should not be initiated until at least 8 weeks after completion of the first course because patients may continue to improve following discontinuation of treatment.

****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: 8/20/2015
REVISED/UPDATED: 10/23/2015; 12/22/2015; 12/29/2016; 8/8/2017. 8/26/2017.