OPTIMA HEALTH COMMUNITY CARE

PHARMACY 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 forms will delay the authorization process.***

Drug Requested: ***Adderall XR® (Preferred)*** **MEDICAID**

DRUG INFORMATION

Drug Form/Strength: _____

Dosing Schedule/Frequency: _____

Quantity Requested: _____ **Total Daily Dose:** _____

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

CLINICAL CRITERIA

- If a trial and failure of a Preferred drug occurs and the physician requests Adderall XR® or amphetamine salts combo XR, **brand** Adderall XR® is ***preferred*** over the generic.

List pharmaceutical agents attempted and outcome: _____

_____

_____

MEDICAL NECESSITY*: *Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this patient.

_____

_____

_____

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 #: _____ Member Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~7/6/2017;~~ **8/28/2017**