

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 forms will delay the authorization process.

Drug Requested: Colcryst™ (colchicine, USP) (*Non-Preferred*) MEDICAID

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form: _____ Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Length of Authorization: 1 year

CLINICAL CRITERIA: Applicable box (es) below must be checked or authorization process will be delayed.

- Patient has diagnosis of Familial Mediterranean Fever;

OR

- Acute Gout Flare:
 - Trial and failure of one of the following:
 - NSAID or corticosteroid

****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: 6/30/2017 8/28/2017.