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: ***Pancreatic Enzymes*** **MEDICAID**

DRUGS: Check box(es) below that apply. If not checked, authorization process will be delayed.

Preferred Pancrelipase	Non-Preferred Pancrelipase
❑ Creon®	❑ Pancreaze®
❑ Zenpep®	❑ Pertzye®
❑ pancrelipase (generic)	❑ Ultresa®
	❑ Viokace®

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

Drug Name/Form: _____ **Strength**: _____

Dosing Schedule: _____ **Length of Therapy**: _____

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

Length of Authorization: 1 year

CLINICAL CRITERIA: Check box for applicable diagnosis or authorization process will be delayed.

- Patient diagnosed with pancreatic insufficiency due to: ***(select one below)***
  - ❑ Cystic Fibrosis **OR** ❑ chronic pancreatitis **OR** ❑ pancreatectomy

For ***ALL*** drugs – if member has a diagnosis of Cystic Fibrosis, there is ***no*** requirement to try and fail a preferred

If patient has a feeding tube, then 2 different pancreatic enzymes can be approved for use together.

****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**