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 the authorization process.***

Drug Requested: Enstilar® (calcipotriene and betamethasone dipropionate) **Foam – Medicaid**
(Non-Preferred)

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

Drug Form: ______________________________ **Strength**: ____________________

Dosing Schedule: ______________________________ **Length of Therapy**: ____________________

Diagnosis: ______________________________ ***ICD Code, if applicable:*** ____________________

Length of Authorization: **4 weeks**

CLINICAL CRITERIA: The following criteria MUST be met or authorization process will be delayed.

- ❑ Patient has a diagnosis of plaque psoriasis

  AND

- ❑ Patient is ≥ 18 years

****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; **8/29/2017**;