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: **Hemangeol**™ (propranolol hydrochloride) ***(Non-Preferred)*** ***MEDICAID***

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

Drug Form: _____ **Strength**: _____

Dosing Frequency: _____ **Length of Therapy**: _____

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

CLINCIAL CRITERIA: ***The following criteria must be met or authorization process will be delayed.***

- ❑ Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy

  AND

- ❑ Member's age must be between 5 weeks and 5 months

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;~~ **8/30/2017**;