

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: *Kapvay*® SR 12H (clonidine hydrochloride extended-release) - [MEDICAID](#)

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

Drug Form/Strength: _____

Dosing Schedule/Frequency: _____ Length of Therapy: _____

Quantity Requested: _____ Total Daily Dose: _____

Diagnosis: _____ ICD Code, if applicable: _____

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

- Trial and failure of at least **one (1) Preferred** drug

List medications attempted and the 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 #: _____ Date of Birth: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/6/2017; 8/31/2017; 10/12/2017