# 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**: **Macrolides & Ketolides, Oral *(Non-Preferred)*** ***MEDICAID***

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

**Drug Form**: _____ **Strength**: _____

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

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

***CLINICAL CRITERIA:* *Check applicable box below that applies. If not checked, authorization process will be delayed.***

- ❑ Infection caused by an organism resistant to preferred drugs

  **OR**

- ❑ A therapeutic failure to no less than a tree-day trial of one preferred drug within the same class;

  **OR**

- ❑ Patient is completing a course of therapy with a non-preferred drug which was initiated in the hospital.

*****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 #: _____ Fax #: _____

**DEA OR NPI #:** _____

***REVISED/UPDATED:** ~~6/29/2017;~~ **8/31/2017**