OPTIMA HEALTH COMMUNITY CARE

PHARMACY STEP-EDIT AUTHORIZATION 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 authorization process.***

Drug Requested: MuGard® (oral mucoadhesive***)***

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:*** _____

RECOMMENDED USE: ***4-6 times a day for management of oral mucositis/stomatitis.***

***MAX dose of MuGard*: 1 bottle (8 fluid ounces/240 mL) per fill**

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. ALL chart notes and lab results MUST be attached to request. Incomplete documentation will delay authorization process.

- ❑ Has the member tried and failed (***paid claims will be documented***):
  - ❑ Oramagic Plus for at least 30 days?

    AND
  - ❑ Magic Mouthwash for at least 30 days?

Medication being provided by a Specialty Pharmacy: ❑ **Sentara Norfolk General CM Pharmacy**

*****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: 8/26/2017**