OPTIMA HEALTH COMMUNITY CARE

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST FORM*

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. All questions must be answered.***

Drug Requested: **Nuplazid™** (pimavanserin) ***(Non-Preferred)*** **MEDICAID**

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

Drug Form/Strength: _____

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

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

Quantity per Day: _____ ***Quantity Limit*:** **2 per day**

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

- Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis
- Patient tried and failed at least ***two (2) Preferred*** medications? ❑ Yes ❑ No

  If *Yes*, please list drugs and outcome: _____

  _____

  _____

  _____

MEDICAL NECESSITY: If requesting a non-preferred drug, please document why a Preferred drug cannot be used.

_____

_____

_____

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 #: _____

UPDATED/REVISED: ~~7/6/2017;~~ **8/31/2017**;