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: ❑ **Onfi**® (clobazam) ***(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:***

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

- ❑ Patient is at least two years of age or older

  AND

- ❑ Patient must have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS);

  AND

- ❑ Using as adjunctive therapy with other anticonvulsants;

  AND

- ❑ Prescribing physician should submit documentation of an insufficient response to another medication used for LGS

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;~~ **8/31/2017**;