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: *(check applicable box below)* ***Platelet Inhibitors (Non-Preferred)*** **MEDICAID**

Preferred Drugs			Non-Preferred Drugs		
❑ Brilinta®	❑ clopidogrel	❑ dipyridamole	❑ Aggrenox®	❑ ASA/dipyridamole	❑ Durlaza® ER
❑ Effient®	❑ ticlopidine HCL		❑ Persantine®	❑ Plavix®	❑ Yosprala® tab
			❑ Zontivity®		

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

- Aspirin is covered without a Prior Authorization.
- Trial and failure of two (2) ***Preferred*** drugs. ***Please list drugs tried and failed***.

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MEDICAL NECESSITY: Provide clinical reason below why aspirin cannot be used.

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