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: ***Proton Pump Inhibitors (PPI) Drugs (Non-Preferred)*** **MEDICAID**

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

Drug Name/Form: _____ **Strength:** _____

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

Length of Authorization: 12 weeks; unless patient meets an exception, then 1 year

CLINICAL CRITERIA: The information below MUST be completed or authorization process will be delayed.

❑ **Initial Request**	❑ **Renewal Request**

NOTE: PDL Criteria *must* be met first before a non-preferred PPI may be approved.

- ***Initial requests*** - may be authorized for ***12 weeks only***.
- ***Renewal requests*** - may be allowed for ***1 year*** if one of the following exceptions has been met:
  - Patient under the care of a Gastroenterologist **OR** patient has a diagnosis of ***ACTIVE*** GI Bleed, Erosive Esophagitis, or Zollinger-Ellison Syndrome.

- Has the patient had a therapeutic failure of no less than a ***3-month trial*** ***of at least TWO*** ***preferred PPIs***? ❑ Yes ❑ No
  If ***Yes***, list medications.
  - **Drug 1**: _____ Strength: _____ Start Date: _____
  - **Drug 2:** _____ Strength: _____ Start Date: _____
  - **Drug 3:** _____ Strength: _____ Start Date: _____

  If ***No***, document compelling details. _____
- Has this patient seen a Gastroenterologist? ❑ Yes ❑ No
  If ***Yes***, document name: _____
- Does this patient have one of the following conditions?
  - ACTIVE GI Bleed ❑ Yes ❑ No
  - Erosive Esophagitis ❑ Yes ❑ No
  - Zollinger-Ellison Syndrome ❑ Yes ❑ No

MEDICAL NECESSITY*: *Provide clinical evidence that the Preferred agent(s) will not provide adequate benefit.

_____

_____

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; 8/4/2017;~~ **8/31/2017**