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 form will delay authorization process.***

Drug Requested: ***(Select one from below)*:**

❑ **Caphosol**® (supersaturated calcium phosphate rinse)	❑ **SalivaMax**™ (supersaturated calcium phosphate rinse)
❑ **NeutraSal**® (supersaturated calcium phosphate rinse)	❑ **Salivate Rx** (supersaturated calcium phosphate rinse)
❑ **Aquoral**® (oxidized glycerol triesters)	

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

*****Note: If approved, a maximum of 120 unit doses per 30 days for supersaturated calcium phosphate rinses or 1 unit (40mL) of Aquoral® per 30 days will be authorized*****

CLINICAL CRITERIA*: *Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed.

For Mucositis Indication, please check all that apply: (two boxes must be checked)

❑ Trial and failure of Magic Mouthwash for ***30 days (must be verified by pharmacy paid claims)***

AND

❑ Trial and failure of lidocaine 2% viscous solution for ***30 days (must be verified by pharmacy paid claims)***

OR

❑ Trial and failure of Mouth Kote® solution for ***30 days (must be verified by pharmacy paid claims)***

For Xerostomia or Hyposalivation Indications, please check all that apply: (One box must be checked)

❑ Trial and failure of Mouth Kote® solution for ***30 days (must be verified by pharmacy paid claims)***

OR

❑ Trial and failure of Biotene Dry Mouth Moisturizing Spray, Biotene Dry Mouth Oral Rinse or Biotene Moisturizing Oral Rinse for ***30 days (must be verified by pharmacy paid claims for MEDICAID members)***

*****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**