# 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 the authorization process.***

**Drug Requested:** **Soma®** (carisoprodol)/carisoprodol products) ***(Non-Preferred)*** **MEDICAID**

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

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

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

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

**Quantity per Day:** _____ ***Quantity Limit*** **– 4 tablets per day**

***Length of Authorization*****: 1 month** ***(Renewal requests will NOT be granted for 6 months following last day of previous course of therapy.)***

| ❑ **Initial Request** | ❑ **Renewal Request** |
|---|---|

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

- Is the patient 16 years of age or older? ❑ Yes ❑ No
- Does the patient have an ***ACUTE***, painful musculoskeletal condition? ❑ Yes ❑ No

Please indicate diagnosis: _____

_____

***List pharmaceutical agents attempted and outcome*****:**

_____

_____

_____

****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**