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: ***Topical Acne Drugs - Dermatologic (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*:** _____

Prior authorization for a cosmetic indication cannot be approved.

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

- Patient is ≥ 18 years of age ***(PA is required to evaluate treatment diagnosis)***

  AND

- Patient has tried and failed ***at least two (2) Preferred*** drugs;

  List previous medications (including name of drug and dose) below:

  _____

  _____

  _____

  AND

- Drugs are intended for ***ACNE ONLY*****.**

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; 8/23/2017;~~ **9/1/2017**