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: **Topical Antifungals *(Non-Preferred)*** **MEDICAID**

DRUG INFORMATION: Complete the 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: ______________________________

CLINICAL CRITERIA AND DIAGNOSIS: –Answer ALL questions to facilitate processing. If not checked, authorization process will be delayed.

Topical Onychomycosis Agents

(to receive a ONE (1) year approval for these drugs, please complete the questions below.)

Does the patient meet the following criteria?

- Diagnosis of onychomycosis? ❑ Yes ❑ No
- Diagnosis of athlete's foot (tinea pedis) or ringworm (tinea cruris, tinea corporis) ❑ Yes ❑ No
- Is the patient 18 years of age or older? ❑ Yes ❑ No
- **Penlac**®, **CNL-8**™, **Jublia**®: must have failure of an adequate trial of 1 oral alternative – terbinafine ***(6 weeks for fingernail infections; 1 week for toenail infections);*** fluconazole ***(6 months)***; itraconazole ***(60 days for fingernail infections; 90 days for toenail)*** ❑ Yes ❑ No
- **Luzu**®: must have failure of an adequate trial of ***two (2) preferred*** topical antifungal medications, **OR** ❑ Yes ❑ No
  Allergy or contraindication to oral terbinafine, fluconazole or itraconazole? ❑ Yes ❑ No

MEDICAL NECESSITY: Provide clinical evidence that supports the use of the requested medication.

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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: ~~6/320/2017;~~ **9/1/2017**