

# 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 (please select one):**

**Topical Immunomodulators**

<input type="checkbox"/> Zyclara® (imiquimod) 2.5% Pump	<input type="checkbox"/> Veregen® (sinecatechins) Ointment
<input type="checkbox"/> Zyclara® (imiquimod) 3.75% Packets/Pump	<input type="checkbox"/> Solaraze® (diclofenac) 3% Gel

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

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

**CLINICAL CRITERIA:** ALL boxes must be checked to qualify or authorization process will be delayed..

**For Actinic Keratosis:**

(Both boxes must be checked)

- Patient has a diagnosis of actinic keratosis
- Requested product:
  - Zyclara® 2.5% Pump
  - Zyclara® 3.75% Packets/Pump
  - Solaraze® 3% Gel

**For External Genital and Perianal Warts/Condyloma Acuminata:**

(Two boxes must be checked)

- Patient has a diagnosis of external genital and/or perianal warts/condylomata acuminata

**AND**

- Patient has a documented trial and inadequate response or clinically significant adverse reaction to generic Aldara™ 5% cream (submit chart notes)

**OR**

- Patient has a documented trial and inadequate response or clinically significant adverse reaction to topical podofilox (submit chart notes)

**\*\*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 #: \_\_\_\_\_