

# OPTIMA HEALTH PLAN

## 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 1-800-750-9692. 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 request.*

### Drug Requested:

### Compound Drug(s)

#### Ingredients:

#### Drug

#### Strength

#### Drug

#### Strength

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The Compound **must** contain at least **one FDA-approved** prescription drug and the prescription ingredients **must** be in therapeutic amounts recognized by national compendia or peer-reviewed medical literature.

Indication: \_\_\_\_\_

Dosage form of compound: \_\_\_\_\_

**CLINICAL CRITERIA:** Check information below. Information **must** be met to qualify. If incomplete, authorization process will be delayed.

- National Compendia reference or two (2) peer-reviewed randomized controlled trials supporting the efficacy and safety of this compound are attached to this request.

#### AND

- Patient has tried and failed at least three (3) FDA-approved commercially available therapeutic alternatives and at least one of the alternatives is of the same route of administration as the compound:

- |                                  |                                |
|----------------------------------|--------------------------------|
| <input type="radio"/> Drug _____ | Route of administration: _____ |
| <input type="radio"/> Drug _____ | Route of administration: _____ |
| <input type="radio"/> Drug _____ | Route of administration: _____ |

#### AND

- The strength requested is **not** commercially available

Compounds containing the following must be in the same dosage form as commercially available specific drug products: diclofenac, flurbiprofen, fluticasone, gabapentin, ketamine, ketoprofen, levoceterizine and mometasone.

**Compounds used for cosmetic indications are excluded from the benefit and will be denied.**

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

\*Approved by Pharmacy and Therapeutics Committee: 3/19/2015

REVISED/UPDATED: 4/15/2015; 5/22/2015; 12/29/2015; 12/15/2016; 9/19/2017.