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 process.*

Drug Requested ***(select one)***: ***Atypical Antipsychotics***

❑ aripiprazole (generic **Abilify**®)	❑ quetiapine ER (generic **Seroquel XR**®)	❑ paliperidone (generic **Invega**®)

***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***: _____

If diagnosis is any type of depressive disorder, please list current antidepressant therapy:

_____

_____

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

❑ Patient has tried and failed ***at least 30 days*** of therapy with ***two (2)*** of the following:

❑ risperidone	❑ quetiapine
❑ ziprasidone	❑ olanzapine
❑ aripiprazole	

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:** 4/15/2010
REVISED/UPDATED: ~~2/3/2011; 9/14/2011; 2/16/2012; 04/19/2012; 5/25/2012; 7/1/2012; 3/20/2014; 11/5/2014; 5/22/2015; 12/29/2015; 7/21/16; 8/3/2016; 9/20/2016; 12/15/2016; 1/19/2017;~~ **9/19/2017**