

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 (Choose one from below):

<input type="checkbox"/> Emverm® (mebendazole)	<input type="checkbox"/> Albenza® (albendazole)
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DRUG INFORMATION: Complete all information below. If incomplete, authorization process will be delayed.

Drug Name/Form/Strength: _____

Requested Dose: _____ Length of Therapy: _____

Indication/Diagnosis: _____ ICD Code, if applicable: _____

{Trial of pyrantel pamoate required for Pinworm and Hookworm infections.}

Listed below are the Center for Disease Control recommendations for treatment of Pinworm and Hookworm:

<i>CDC Recommendations for <u>Pinworm</u> Treatment</i>	<i>Dosage for Adults and Children</i>
Pyrantel pamoate	11mg/kg base PO once; repeat in 2 weeks
Mebendazole	100mg PO once; repeat in 2 weeks
Albendazole	For children ≥20kg: 400mg PO once; repeat in 2 weeks For children <20kg: 200mg PO once; repeat in 2 weeks

<i>CDC Recommendations for <u>Hookworm</u> Treatment</i>	<i>Dosage for Adults and Children</i>
Pyrantel pamoate	11mg/kg (up to a maximum of 1gm) PO daily for 3 days
Mebendazole	100mg PO BID for 3 days or 500mg orally once
Albendazole	400mg PO once

CLINICAL CRITERIA: All boxes **MUST** be checked to qualify or authorization process will be delayed. *{Indication, length of therapy, and requested dose must be noted above.}*

- For Pinworm infection: Patient has tried and failed at least 2 doses of a pyrantel pamoate product - initial dose followed by second dose 2 weeks later. Paid pharmacy claim for a pyrantel pamoate product **MUST** be noted in patient's pharmacy profile.

OR

- For Hookworm infection: Patient has tried and failed at least 3 consecutive daily doses of a pyrantel pamoate product. Paid pharmacy claim for a pyrantel pamoate product **MUST** be noted in patient's pharmacy profile.

****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 #: _____