

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: **Auvi-Q® (epinephrine injection) Auto-Injector**

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: The box below **MUST** be checked. Chart notes documenting administration and failure of EpiPen® product or its generic resulting in medical intervention, such as an emergency room visit, **MUST** be attached to this request form. If incomplete, authorization process will be delayed.

- Patient experienced treatment failure with EpiPen®, EpiPen Jr® or generic EpiPen/Jr and resultant medical intervention was required

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: 1/21/2016
REVISED/UPDATED: 3/29/2016; 12/15/2016; 9/19/2017