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 below)*:

❑ **Doryx®** (doxycycline hyclate DR)	❑ **doxycycline hyclate DR**	❑ **Acticlate®** (doxycycline hyclate)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Name/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.

- ❑ Patient has tried and failed at least ***30 days*** of therapy with:
  - ❑ Topical clindamycin or erythromycin

    AND
  - ❑ Generic immediate release doxycycline

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**: 1/20/2011

REVISED/UPDATED: ~~3/30~~/2011; ~~6/14/2011~~; ~~8/12/2011~~; ~~9/14/2011~~; ~~3/20/2014~~; ~~4/29/2015~~; ~~5/27/2015~~; ~~8/11/2015~~; ~~12/25/2015~~; ~~12/29/2016~~; **9/19/2017**