

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: (Please check applicable drug)

Millipred™ Oral Solution (prednisolone sodium phosphate)

Veripred™ 20 Oral Solution (prednisolone sodium phosphate)

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: _____

CLINICAL CRITERIA: Following criteria below **MUST** be met or authorization process will be delayed.

- Patient has tried and failed therapy with a generic prednisolone phosphate solution or syrup (***submission of pharmacy records may be required to verify medication trials***)

****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: 7/16/2015

REVISED/UPDATED: 8/11/2015; 12/27/2015; 9/28/2016; 12/19/2016; 9/21/2017.