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***): **Ocular Antihistamines**

❑ **Emadine**® (emedastine difumarate ophthalmic solution 0.05%)	❑ olopatadine hydrochloride ophthalmic solution 0.1%

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

❑ Member has tried **ONE (1)** of the following (***check each drug tried***):

❑ azelastine	❑ epinastine	❑ ketotifen

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:** 4/18/2013

REVISED/UPDATED: ~~6/30/2013; 3/20/2014; 11/2/2014; 5/21/2015; 8/3/2015; 8/26/2015; 12/28/2015; 12/19/2016; 2/2/2017; 2/9/2017; 5/5/2017;~~ **9/22/2017**