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 select one)*: ***Topical Acne Drugs***

❑ tretinoin 0.05% (generic **Atralin®**)	❑ clindamycin/tretinoin 1.2% -0.025% (generic **Veltin®**)
❑ tretinoin microsphere 0.04%, 0.1% (generic **Retin-A Micro®**)	❑ clindamycin/tretinoin 1.2% – 0.025% (generic **Ziana®**)
❑ **Tazorac®** (tazarotene)	

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: Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed. Chart notes (documentation) MUST be attached to request.

- Patient diagnosed with acne vulgaris
- Patient is ≥ 29 years of age (***documentation required for Differin®, Retin-A®, or tretinoin***)
- Patient must have documentation of at least a ***30 day trial and failure*** of ***THREE (3)*** of the following:

❑ adapalene*	❑ benzoyl peroxide/erythromycin	❑ sodium sulfacetamide
❑ benzoyl peroxide	❑ clindamycin topical	❑ sodium sulfacetamide/sulfur
❑ benzoyl peroxide/clindamycin	❑ erythromycin topical	❑ tretinoin* ***(generic Retin-A)***

****adapalene and tretinoin require prior authorization if used as treatment in a patient greater than 29 years of age. The prior authorization form can be downloaded from: http://providers.optimahealth.com/pharmacy***

*****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**: 4/17/2014
REVISED/UPDATED: 5/8/2014; 5/28/2014; 6/10/2014; 7/29/2014; 8/6/2014; 9/23/2014; 11/5/2014; 2/19/2015; 5/27/2015; 7/23/2015; 8/11/2015; 10/19/2015; 12/29/2015; 4/21/2016; 5/6/2016; 12/20/2016; 1/19/2017; **9/23/2017**;