

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 Rosacea Drugs**

- metronidazole 1% (generic **Metrogel**®)

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: ALL applicable boxes below must be checked to qualify or authorization process will be delayed.

For Metrogel®

- Diagnosis of **Rosacea with inflammatory lesions**

AND

- 30 day trial and failure** of generic, **topical metronidazole 0.75%**

****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: 4/21/2016

REVISED/UPDATED: 5/9/2016; 12/20/2016; 1/19/2017; 9/23/2017.