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 (pick one) **Anticonvulsants:**

❑ **Aptiom®** (eslicarbazepine)	❑ **Briviact®** (brivaracetam)
❑ **Fycompa®** (perampanel)	❑ **Onfi®** (clobazam)
❑ **Spritam®** (levetiracetam)	❑ **Vimpat®** (lacosamide)

DRUG INFORMATION: Complete information below or authorization will be delayed.

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. Chart notes (documentation) of failure **MUST** be attached to this request.

❑ Patient has tried or is currently taking at least **two (2)** of the following anticonvulsants:

❑ carbamazepine	❑ gabapentin	❑ lamotrigine
❑ levetiracetam	❑ oxcarbazepine	❑ phenobarbital
❑ phenytoin	❑ pregabalin	❑ topiramate
❑ valproate/valproic acid	❑ zonisamide	

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**: 2/16/2012
REVISED/UPDATED: ~~7/1/2012; 10/17/13; 11/20/2013; 12/27/2013; 11/2/2014; 1/15/2015; 5/21/2015; 12/27/2015; 6/16/2016; 8/22/2016; 9/20/2016; 12/15/2016; 8/9/2017;~~ **9/24/2018**