

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 (Check applicable drug below):

<input type="checkbox"/> Differin® (adapalene)	<input type="checkbox"/> Tretin-X® (tretinoin)
<input type="checkbox"/> Retin-A® (tretinoin)	<input type="checkbox"/> tretinoin

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: _____

- Differin®, Retin-A®, Tretin-X® and tretinoin are restricted to **NON-COSMETIC** purposes only.

Off-label use for actinic keratosis will be limited to generic tretinoin.

CLINICAL CRITERIA: Check the box (es) below that apply or authorization process will be delayed.

- **Diagnosis:**
 - acne vulgaris and patient is greater than 29 years of age
- **Diagnosis (for generic tretinoin only):**
 - actinic keratosis

MEDICAL NECESSITY: Provide clinical evidence below that the preferred drug will not provide adequate benefit.

****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: 9/16/2010

REVISED/UPDATED: 6/1/2011; 8/12/2011; 4/7/2014; 10/30/2014; 5/21/2015; 11/20/15; 12/22/2015; 12/30/2016; 8/12/2017