

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):

Doryx® (doxycycline hyclate DR) doxycycline hyclate DR Acticlate® (doxycycline hyclate)

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

- Patient has tried and failed at least **30 days** of therapy with:
- Topical clindamycin or erythromycin
- AND**
- Generic immediate release doxycycline

****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: 1/20/2011

REVISED/UPDATED: 3/30/2011; 6/14/2011; 8/12/2011; 9/14/2011; 3/20/2014; 4/29/2015; 5/27/2015; 8/11/2015; 12/25/2015; 12/29/2016; 8/9/2017