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 the drug below that applies):

❑ **EryPed®** (erythromycin ethylsuccinate) **Oral Suspension**	❑ **E.E.S. Granules** (erythromycin ethylsuccinate) **for Oral Suspension**	❑ **erythromycin ethylsuccinate oral suspension**

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

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: **ALL** criteria below **must** be met for approval.

For Diagnosis of Gastroparesis – Initial therapy request for 30-day approval:

- ❑ Patient must be > 18 years of age

AND

- ❑ Patient must have a documented diagnosis of gastroparesis

AND

- ❑ Patient must have had an unsuccessful 30-day trial of metoclopramide **(chart notes MUST be submitted for documentation and pharmacy paid claim must be noted)**

AND

- ❑ Medication will be approved for a maximum of 30 days only due to tachyphylaxis

For Diagnosis of Gastroparesis – Continuation of therapy request for additional 30 days:

- ❑ Patient must be >18 years of age

AND

- ❑ Patient must have a documented diagnosis of gastroparesis

AND

- ❑ Patient must have had an unsuccessful 30 day trial of metoclopramide **(chart notes MUST be submitted for documentation and pharmacy paid claim must be noted)**

AND

- ❑ Chart notes **MUST** be submitted to document positive response to 30-day trial of erythromycin suspension and medical necessity for continuation of therapy

For all other Diagnoses:

- ❑ Patient must be >18 years of age

AND

(continued on next page)

- ❑ Patient's diagnosis must be noted: _____

AND

- ❑ Length of therapy requested: _____

AND

- ❑ Patient **MUST** be unable to swallow tablets **(chart notes must be submitted to document clinically significant contraindication to use of erythromycin tablets, such as radiation therapy of head/neck)**

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:** 7/19/2018
REVISED/UPDATED: 9/25/2018