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.***

Irritable Bowel Disease (IBD) *(NON-PREFERRED) (Commercial Only)*

DRUG REQUESTED: ***Check applicable box below.***

❑ **Asacol® HD**	❑ **Colazal®**	❑ **Delzicol®**	❑ **Dipentum®**
❑ **Lialda®**	❑ **Mesalamine DR 800mg**	❑ **Uceris® Foam w/o UM**	

DRUG INFORMATION: ***Complete information below. If incomplete, authorization process will be delayed.***

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA*: *Box MUST be checked below to qualify or authorization process will be delayed.

❑ Trial and failure of ***at least 30 days therapy*** with Apriso®

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**: 10/19/2017
Revised/Updated: 12/13/2017