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***):

❑ **Julia**® (efinaconazole)	❑ **Kerydin**® (tavaborole)

***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*: Following criteria must be met to qualify or authorization process will be delayed.**

- Patient has tried and failed at least ***48 weeks*** (consecutive) of therapy with ciclopirox:
  - ❑ ciclopirox 8% nail lacquer (generic Penlac)

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:** 11/19/2015
REVISED/UPDATED: ~~3/29/2016; 12/19/2016;~~ **8/14/2017**