

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: Lidocaine Viscous 2%

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Maximum daily dose limited to 10 mL/day.

CLINICAL CRITERIA: The following criteria **MUST** be met or authorization process will be delayed.

Patient is \geq 3 years old

AND

Patient is using this to relieve oral inflammation or irritation.

*****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 the Pharmacy and Therapeutics Committee: 9/18/2014
REVISED/UPDATED: 12/22/2014; 5/22/2015; 12/28/2015; 12/21/2016; 8/14/2017