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: **Metozolv® ODT** (Metoclopramide Oral Disintegrating Tabs)

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***: ______________________

- ***Duration of therapy must not exceed 12 weeks***

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

- ❑ Patient has tried and failed:
  - ❑ Metoclopramide (Oral tablet, Solution, or syrup)

*****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**: ~~8/19/2010~~
REVISED/UPDATED: ~~6/2/2011; 8/22/2011; 4/9/2014; 11/2/2014; 5/22/2015; 12/28/2015; 12/19/2016;~~ **8/14/2017**;