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): Ocular Antihistamines

❑ **Bepreve®** (bepotasline besilate ophthalmic solution 1.5%)	❑ **Emadine®** (emedastine difumarate ophthalmic solution 0.05%)
❑ **Lastacaft®** (alcaftadine ophthalmic solution 0.25%)	❑ **Pataday®** (olopatadine hydrochloride ophthalmic solution 0.2%)
❑ **Pazeo™** (olopatadine hydrochloride ophthalmic solution 0.7%)	

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

Drug Name/Form/Strength: _____

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

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

CLINICAL CRITERIA: **All** boxes below **must** be checked to qualify to ensure authorization will **NOT** be delayed.

❑ Member has tried at least **ONE (1)** of the following **(check each drug tried)**:

❑ azelastine	❑ epinastine	❑ ketotifen	❑ olopatadine hydrochloride ophthalmic solution 0.1%

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:** 4/18/2013
REVISED/UPDATED: ~~6/30/2013; 3/20/2014; 11/2/2014; 5/21/2015; 8/3/2015; 8/26/2015; 12/28/2015; 12/19/2016; 8/15/2017;~~ **10/10/2018**