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 forms will delay the authorization process.***

Drug Requested: ***Pancreatic Enzymes (Non-Preferred Pancrelipase)***

DRUGS: Check box(es) below that apply. If not checked, authorization process will be delayed.

❑ **Pancreaze®**	❑ **Pertzye®**	❑ **Ultresa®**	❑ **Viokace®**

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

Drug Name/Form: _____ **Strength**: _____

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

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

CLINICAL CRITERIA: Check box for applicable diagnosis or authorization process will be delayed.

- Trial and failure of ***BOTH*** of the following ***PREFERRED*** pancrelipases below***:***

❑ Creon®	❑ Zenpep®

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: 12/12/2017**