

# 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 from below):

<input type="checkbox"/> <b>Caphosol®</b> (supersaturated calcium phosphate rinse)	<input type="checkbox"/> <b>SalivaMax™</b> (supersaturated calcium phosphate rinse)
<input type="checkbox"/> <b>NeutraSal®</b> (supersaturated calcium phosphate rinse)	<input type="checkbox"/> <b>Salivate Rx</b> (supersaturated calcium phosphate rinse)
<input type="checkbox"/> <b>Aquoral®</b> (oxidized glycerol triesters)	

**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: \_\_\_\_\_

**\*\*Note: If approved, a maximum of 120 unit doses per 30 days for supersaturated calcium phosphate rinses or 1 unit (40mL) of Aquoral® per 30 days will be authorized\*\***

**CLINICAL CRITERIA:** Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed.

**For Mucositis Indication, please check all that apply: (two boxes must be checked)**

Trial and failure of Magic Mouthwash for 30 days (must be verified by pharmacy paid claims)

**AND**

Trial and failure of lidocaine 2% viscous solution for 30 days (must be verified by pharmacy paid claims)

**OR**

Trial and failure of Mouth Kote® solution for 30 days (must be verified by pharmacy paid claims)

**For Xerostomia or Hyposalivation Indications, please check all that apply: (One box must be checked)**

Trial and failure of Mouth Kote® solution for 30 days (must be verified by pharmacy paid claims)

**OR**

Trial and failure of Biotene Dry Mouth Moisturizing Spray, Biotene Dry Mouth Oral Rinse or Biotene Moisturizing Oral Rinse for 30 days (must be verified by pharmacy paid claims for MEDICAID members)

**\*\*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: 8/25/2016

REVISED/UPDATED: 11/14/2016; 12/12/2016; 8/17/2017