OPTIMA HEALTH PLAN

PHARMACY/MEDICAL 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; **(Pharmacy) 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Select from one below:

❑ **Sklice® lotion** (ivermectin)	❑ **Ulesfia™** (benzyl alcohol)

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

Drug Form/Strength: ____

Dosing Schedule: ______________________ **Length of Therapy**: ______________

Diagnosis: __________________________ **ICD Code, if applicable:** ____________

Hair Length		**Amount of Ulesfia™ Lotion per Application**		**Recommended Number of Bottles per Application**	**Total Number of Bottles for Complete Treatment**
Short	0-2 inches	4-6 oz.	½ - ¾ bottle	1	2
	2-4 inches	6-8 oz.	¾ - 1 bottle	1	2
Medium	4-8 inches	8-12 oz.	1- 1½ bottles	1.5	3
	8-16 inches	12-24 oz.	1½- 3 bottles	3	6
Long	16-22 inches	24 – 32 oz.	3- 4 bottles	4	8
	Over 22 inches	32-48 oz.	4- 6 bottles	6	12

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

❑ Patient has tried and failed a complete course **(administration and re-administration after 7 days)** of **one (1)** formulary OTC Permethrin 1% product **(**Family Care patients must have paid pharmacy claim for a Permethrin 1% product**)**

AND

❑ Patient has tried and failed generic Ovide lotion (malathion)

*****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**: 10/15/2009
REVISED/UPDATED: ~~6/6/2011; 9/9/2011; 11/5/2014; 8/20/2015; 10/23/2015; 12/22/2015; 12/20/2016; 8/19/2017;~~ **3/7/2019**