

# 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:** Solodyn® (minocycline)

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

**RECOMMENDED DOSAGE:** approximately 1mg/kg once daily for 12 weeks.

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

- Patient is  $\geq$  12 years of age
  - Patient has tried and failed:
    - Topical clindamycin or erythromycin
- AND**
- Minocycline

**\*\*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: 1/20/2011

REVISED/UPDATED: 3/30/2011; 6/14/2011; 9/8/2011; 6/13/2012; 5/8/2014; 11/5/2014; 5/22/2015; 12/29/2015; 12/20/2016; 8/17/2017