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: ***Check drug below that applies or authorization process will be delayed.***

❑ **Solodyn®** (minocycline)	❑ **Ximino™** (minocycline hydrochloride)	❑ **minocycline ER**

***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 ≥ 12 years of age
- ❑ Patient has had an unsuccessful 30 day trial of both of the following:
  - ❑ Topical clindamycin or erythromycin

    AND
  - ❑ Minocycline Immediate Release (IR)

*****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;~~ **6/14/2018**