# 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 will be delayed.**

| | | |
|---|---|---|
| ❑ **Solodyn®** (minocycline) | ❑ **Ximino™** (minocycline hydrochloride) | ❑ **minocycline ER** |
| ❑ **Minolira®** (minocycline ER) | ❑ **CoreMino®** (minocycline ER) | |

**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:** _____

**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 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) tablet or capsule

***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;~~ **12/31/2018**