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 ***(please select one):*** ***Topical Acne Drugs***

❑ **Acanya**® (clindamycin/benzoyl peroxide)	❑ **Fabior**™ (tazarotene)
❑ **Aczone**® (dapsone)	❑ **Neuac**™ **Kit** (clindamycin/benzoyl peroxide)
❑ **Atralin**® (tretinoin)	❑ **Onexton**™ (clindamycin/benzoyl peroxide)
❑ **Azelex**® (azelaic acid)	❑ **Retin-A Micro**® (tretinoin microsphere)
❑ **Benzaclin**® **Pump** (clindamycin/benzoyl peroxide)	❑ **Tazorac**® (tazarotene)
❑ **Clindagel**® (clindamycin)	❑ **Veltin**® (clindamycin/tretinoin)
❑ **EpiDuo/Forte**® (adapalene/benzoyl peroxide)	❑ **Ziana**® (clindamycin/tretinoin)

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*:** _____

CLINICAL CRITERIA*: *Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed. Chart notes (documentation) MUST be attached to request.

- Patient diagnosed with acne vulgaris
- Patient is ≥ 29 years of age (***documentation required for Differin®, Retin-A®, or tretinoin***)
- Patient must have documentation of at least a ***30 day trial and failure*** of ***THREE (3)*** of the following:

❑ adapalene*	❑ benzoyl peroxide/erythromycin	❑ sodium sulfacetamide
❑ benzoyl peroxide	❑ clindamycin topical	❑ sodium sulfacetamide/sulfur
❑ benzoyl peroxide/clindamycin	❑ erythromycin topical	❑ tretinoin* ***(generic Retin-A)***

****adapalene and tretinoin require prior authorization if used as treatment in a patient greater than 29 years of age. The prior authorization form can be downloaded from: http://providers.optimahealth.com/pharmacy***

*****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**: 4/17/2014
REVISED/UPDATED: 5/8/2014; 5/28/2014; 6/10/2014; 7/29/2014; 8/6/2014; 9/23/2014; 11/5/2014; 2/19/2015; 5/27/2015; 7/23/2015; 8/11/2015; 10/19/2015; ~~12/29/2015~~; 4/21/2016; 5/6/2016; 12/20/2016; **8/18/2017**