

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 (select one below): Topical Corticosteroids

<input type="checkbox"/> Apexicon E	<input type="checkbox"/> Halog	<input type="checkbox"/> Texacort
<input type="checkbox"/> Capex Shampoo	<input type="checkbox"/> Kenalog Aer Spray	<input type="checkbox"/> Topicort
<input type="checkbox"/> Clobex	<input type="checkbox"/> Locoid	<input type="checkbox"/> Trianex
<input type="checkbox"/> Cordran/SP/Tape	<input type="checkbox"/> Pandel	<input type="checkbox"/> Ultravate Lotion
<input type="checkbox"/> Desonate	<input type="checkbox"/> Sernivo Spray	<input type="checkbox"/> Vanos
<input type="checkbox"/> Enstilar	<input type="checkbox"/> Taclonex	<input type="checkbox"/> Verdeso
<input type="checkbox"/> Impoyz™ Cream		

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: The following criteria **must** be met to ensure authorization is NOT being delayed.

Trial and failure of **at least three (3)** of the following **generic** topicals:

<input type="checkbox"/> alclometasone dipropionate	<input type="checkbox"/> desonide	<input type="checkbox"/> HC butyrate
<input type="checkbox"/> amcinonide	<input type="checkbox"/> desoximetasone	<input type="checkbox"/> HC valerate
<input type="checkbox"/> augmented betamethasone	<input type="checkbox"/> diflorasone	<input type="checkbox"/> hydrocortisone (2.5%)
<input type="checkbox"/> betamethasone dipropionate	<input type="checkbox"/> fluocinolone	<input type="checkbox"/> mometasone
<input type="checkbox"/> betamethasone valerate	<input type="checkbox"/> fluocinonide	<input type="checkbox"/> prednicarbate
<input type="checkbox"/> clobetasol	<input type="checkbox"/> fluticasone	<input type="checkbox"/> triamcinolone
<input type="checkbox"/> clocortolone pivalate	<input type="checkbox"/> halobetasol	

****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: 2/20/2014
 REVISED/UPDATED: 5/8/2014; 7/22/2014; 9/26/2014; 9/29/2014; 11/5/2014; 5/22/2015; 11/20/2015; 12/22/2015; 6/16/2016; 8/15/2016; 9/28/2016; 12/20/2016; 8/19/2017; 6/14/2018