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; (Pharmacy) 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: (check applicable box below) Topical Rosacea Drugs

- Finacea® (azelaic acid)
- Metrogel® (metronidazole)
- Noritate® (metronidazole)
- Soolantra® (ivermectin)

**DRUG INFORMATION:** Complete information below or authorization 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. ALL criteria must be met for approval. ALL documentation including labs or chart notes (if required) must be submitted or request will be denied.

For Finacea®, Metrogel®, and Soolantra®:

- Diagnosis of Rosacea with inflammatory lesions

  AND

- 30 day trial and failure of generic, topical metronidazole 0.75%

For Noritate®:

- Diagnosis of Rosacea with inflammatory lesions

  AND

- 30 day trial and failure of generic, topical metronidazole 0.75%

  AND

- 30 day trial and failure of Finacea® (requires prior authorization)

  AND

- 30 day trial and failure of Soolantra® (requires prior authorization)

(continued on next page; signature page must be attached to this request form)
**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: 4/21/2016
REVISED/UPDATED: 5/9/2016; 12/20/2016; 8/19/2017*