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: **Vivlodex®** (meloxicam)

DRUG INFORMATION: ***Complete information below. If incomplete, authorization process will be delayed.***

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA*: *Boxes MUST be checked below to qualify or authorization process will be delayed. Chart documentation MUST be attached to this request.

❑ Member tried and failed ***one (1)*** of the following topical agents:

❑ diclofenac 1% gel	**OR**	❑ diclofenac 1.5% solution

AND

❑ Member tried and failed ***four (4) generic NSAIDs*** from the Optima Preferred Drug List listed below. ***ONE must be meloxicam***. ***Please indicate which NSAIDS tried below:***

❑ diclofenac sodium	❑ diflunisal	❑ etodolac
❑ fenoprofen	❑ flurbiprofen	❑ ibuprofen
❑ indomethacin, SR	❑ ketoprofen, SR	❑ ketorolac
❑ meclofenamate	❑ nabumetone	❑ naproxen
❑ naproxen sodium	❑ oxprozin	❑ piroxicam
❑ sulindac	❑ tolmetin	❑ meloxicam

*****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**: 9/21/2017
REVISED/UPDATED: 11/24/2017