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 of the following)*:**

❑ **Xadago®** (safinamide)	❑ **Zelapar ODT** (selegiline ODT)

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***: _____

Recommended dosing: ***start with 50mg once daily at the same time; after two weeks may be increased to 100mg***

CLINICAL CRITERIA*: *Box MUST be checked below to qualify or authorization process will be delayed.

- Patient ***MUST*** have tried and failed ***one*** of the following ***(check box below that applies)***:
  - ❑ selegiline **OR** ❑ rasagiline

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**: 10/19/2017
Revised/Updated: ~~12/18/2017;~~ **2/21/2018**