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: Zegerid Packets® (omeprazole/sodium bicarbonate 40mg - 1100mg)

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

Drug Name/Form: _____

Strength/Quantity per Day: _____

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

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

CLINICAL CRITERIA: The following criteria MUST be met. Check below ALL that apply to qualify or authorization process will be delayed**.**

- ❑ **Member tried and failed 30 day trials of four (4) generic PPIs from the following:**

❑ omeprazole 40mg	❑ lansoprazole 30mg
❑ pantoprazole 20mg, 40mg	❑ rabeprazole 20mg
❑ esomeprazole 40mg	

AND

- ❑ Member tried and failed **30 day trial** of **the Brand PPI** Dexilant® (dexlansoprazole) **(requires Prior Authorization; form can be found at www.optimahealth.com)**

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**: 12/17/2015
REVISED/UPDATED: ~~12/17/2015~~; ~~3/31/2016~~; ~~12/20/2016~~; ~~8/21/2017~~; ~~9/24/2017~~; ~~12/5/2017~~; ~~3/28/2018~~; **2/15/2019**