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: ***(check applicable drug below)***

❑ **Zegerid**® (omeprazole/sodium bicarbonate 40mg - 1100mg)	❑ **Vimovo**® (esomeprazole-naproxen)
❑ **Duexis**® (ibuprofen-famotidine)	

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

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.

❑ **Patient tried and failed *four (4) generic PPIs* listed below from the Optima Preferred Drug List**:

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

AND

❑ Patient **tried and failed the Brand PPI** Dexilant® (dexlansoprazole) ***(requires Prior Authorization form 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**