

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: **Zuplenz®** (ondansetron oral soluble film)

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: _____

- Patients with severe hepatic impairment - total daily dose of 8mg should **not** be exceeded

CLINICAL CRITERIA: The following criteria **MUST** be met to qualify or authorization process will be delayed.

- Patient has tried and failed ondansetron ODT

****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 & Therapeutics Committee: 1/20/2011

REVISED/UPDATED: 3/30/2011; 9/14/11; 11/6/2014; 5/22/2015; 12/29/2015; 12/20/2016; 8/21/2017.