OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

NON-PREFERRED DRUG REQUEST FORM*
FOR MEDICAL NECESSITY

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 INFORMATION: List requested drug information below.

Drug Name/Form: ______________________________ **Diagnosis** ____________________

Strength/Dose Frequency: ______________________________ **Length of therapy:** ______________

PRESCRIPTION/MEDICAL HISTORY: List previous alternative medications that have been utilized.

Medication Name	Dose	Length of Trial	Outcome
1. ______________________	________	______________	______________
2. ______________________	________	______________	______________
3. ______________________	________	______________	______________
4. ______________________	________	______________	______________

CLINICAL CRITERIA/MEDICAL NECESSITY: Provide clinical evidence that the **PREFERRED** drug(s) will not provide adequate benefit. Attach chart notes.

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(Continued on next page; signature page MUST be included with request.)

(Signature page MUST be included with the request.)

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 #: ______________________ Member Date of Birth: __________

Prescriber Name: ____

Prescriber Signature: ______________________ Date: __________

Office Contact Name: ____

Phone Number: ______________________ Fax Number: __________

DEA OR NPI #: ____

REVISED/UPDATED: 6/27/2017; **9/18/2018**;