OPTIMA HEALTH PLAN

PHARMACY/MEDICAL DRUG NECESSITY 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.***

This form is intended for use when a medication being requested is:

- **A specific preauthorization form is not available**

DRUG INFORMATION: ALL information below MUST be completed or authorization process will be delayed.

Drug/Medication Name: _____

Strength/Form: _____

Diagnosis/Indication: _____ **Duration of therapy:** _____

PREVIOUS THERAPIES FAILED: Complete information below or authorization process will be delayed.

Medication Name	Dose	Length of Trial
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Has the patient failed previous treatment and shown intolerance, or has a contraindication to the covered alternatives? ❑ **Yes** ❑ **No**

If Yes, please describe AND attach chart notes. If incomplete, authorization process will be delayed.

_____

_____

_____

_____

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**: 7/16/1998

REVISED/UPDATED: ~~02/14/2013~~; ~~3/7/2013~~; ~~4/24/2013~~; ~~11/6/2014~~; ~~5/22/2015~~; ~~12/29/2015~~; ~~12/6/2016~~; ~~9/12/2017~~; **11/1/2017**;