

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 will be delayed.

Drug/Medication Name: _____

Strength/Form: _____

Diagnosis/Indication: _____ Duration of therapy: _____

PREVIOUS THERAPIES FAILED: Complete information below to ensure authorization will **NOT** be delayed.

<u>Medication Name</u>	<u>Dose</u>	<u>Length of Trial</u>
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

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