OPTIMA HEALTH PLAN

NON-FORMULARY EXCEPTIONS 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:

- **Non-formulary medication**

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: Information must be completed to ensure authorization is **NOT** 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 #: _____

REVISED/UPDATED: ~~11/1/2017;~~ **10/8/2018**