

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 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.

| <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 #: _____

REVISED/UPDATED: 11/1/2017