OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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. ____________________	________	________________	________________

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

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****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;