OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT 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. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: (select one of the following)

❑ **ibuprofen/famotidine** (Duexis®)	❑ **naproxen/esomeprazole magnesium** (Vimovo®)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Quantity Limits:

- ibuprofen/famotidine (generic Duexis®) – 90 tablets per 30 days
- naproxen/esomeprazole magnesium (generic Vimovo®) – 60 tablets per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Member has tried and failed at least **FOUR** generic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) **(select all that apply; verified by chart notes and/or pharmacy paid claims)**

❑ celecoxib	❑ ibuprofen	❑ nabumetone
❑ diclofenac sodium	❑ indomethacin IR/ER	❑ naproxen
❑ diflunisal	❑ ketoprofen IR	❑ oxaprozin
❑ etodolac	❑ ketorolac	❑ piroxicam
❑ flurbiprofen	❑ meloxicam	❑ sulindac

❑ Member has tried and failed at least **ONE** of the following **(select all that apply; verified by chart notes and/or pharmacy paid claims)**:

❑ esomeprazole	❑ famotidine	❑ lansoprazole
❑ omeprazole	❑ pantoprazole	❑ rabeprazole

❑ Member has tried and had an adequate response (defined as pain relief and appropriate gastro protection) with a trial of naproxen or ibuprofen and a proton pump inhibitor (such as esomeprazole) or histamine receptor antagonist (such as famotidine) used at the same time

❑ Provider has submitted chart notes to document the clinical rationale for why requested combination agent is medically necessary and not only for convenience

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****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.****

Member 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**: 5/19/2022
REVISED/UPDATED: ~~4/26/2022; 6/3/2022;~~ **6/17/2022**