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 the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Nuplazid® (pimavanserin)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Maximum allowable daily dose: 2 tablets/day

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.

- ❑ Patient has a diagnosis of Parkinson's disease psychosis

    AND

- ❑ Psychotic symptoms have been present for at least one month

    AND

- ❑ Psychosis is not due to another cause

    AND

- ❑ Patient does not have a history of cardiac arrhythmias or QT prolongation, and the patient does not use another medication concomitantly that prolongs the QT interval

Medication being provided by a Specialty Pharmacy - PropriumRx

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.

Patient Name: _____

Member Optima #: _____   Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____   Date: _____

Office Contact Name: _____

Phone Number: _____   Fax Number: _____

DEA OR NPI #: _____