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: flucytosine capsules

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Member's Weight: _____

Recommended Dosage: 25 mg/kg/dose every 6 hours

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 a diagnosis of **ONE** of the following:
  - ❑ Documented diagnosis of cryptococcal meningitis
  - ❑ Documented diagnosis of candida endocarditis
  - ❑ Documented diagnosis of a cryptococcal pulmonary infection **AND** documentation of clinical inappropriateness/resistance/treatment failure with at least one first-line agent (e.g., fluconazole, itraconazole, or voriconazole)
  - ❑ Documented diagnosis of candida septicemia **AND** documentation of clinical inappropriateness/resistance/treatment failure with at least one first-line agent (e.g., fluconazole, voriconazole)
  - ❑ Documented diagnosis of candiduria **AND** documentation of clinical inappropriateness/resistance/treatment failure with fluconazole

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**: 11/18/2021
REVISED/UPDATED: 2/4/2022