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.**

Topical Rosacea Drugs

Drug Requested: (check applicable box below)

❑ **Mirvaso®** (brimonidine)	❑ **Rhofade®** (oxymetazoline)
❑ **Soolantra®** (ivermectin)	❑ **Zilxi®** (minocycline)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

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.

❑ **For Mirvaso® and Rhofade® requests, ALL of the following criteria must be met:**

- ❑ Member is 18 years of age or older
- ❑ Member's quality of life has been impacted
- ❑ Member has **ONE** of the following diagnosis:
  - ❑ Persistent (non-transient) facial erythema (subtype erythematotelangiectatic rosacea)
  - ❑ Papulopustular lesions with persistent (non-transient) facial erythema (subtype erythematotelangiectatic rosacea)
- ❑ Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following within the last 6 months **(submit chart notes documenting treatment failure)**:

❑ Oral doxycycline hyclate	❑ Oral minocycline	❑ Oral tetracycline	❑ Topical retinoids (e.g., adapalene, tretinoin) **(*requires prior authorization)**
❑ metronidazole cream 0.75%, ❑ metronidazole 0.75% gel ❑ metronidazole 1% gel	❑ sodium sulfacetamide sulfur 10%/5% ❑ sodium sulfacetamide sulfur 8%/4%	❑ azelaic acid gel 15%	

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❑ **For Soolantra® and Zilxi® requests, ALL of the following criteria must be met:**

- ❑ Member must have papulopustular rosacea and inflammatory lesions
- ❑ Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following within the last 6 months **(submit chart notes documenting treatment failure)**:

❑ Oral doxycycline hyclate	❑ Oral minocycline	❑ Oral tetracycline	❑ Topical retinoids (e.g., adapalene, tretinoin) **(*requires prior authorization)**
❑ metronidazole cream 0.75%, ❑ metronidazole 0.75% gel ❑ metronidazole 1% gel	❑ sodium sulfacetamide sulfur 10%/5% ❑ sodium sulfacetamide sulfur 8%/4%	❑ azelaic acid gel 15%	

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**: ~~4/21/2016;~~ **7/21/2022**

REVISED/UPDATED: ~~5/9/2016; 12/20/2016; 8/19/2017; 12/7/2020; 6/7/2022;~~ **8/22/2022**