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; **(Pharmacy) 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 can be delayed.**

Drug Requested: Select one below:

❑ **Aquoral®** (oxidized glycerol triesters)	❑ **Caphosol®** (supersaturated calcium phosphate rinse)	❑ **NeutraSal®** (supersaturated calcium phosphate rinse)
❑ **SalivaMax™** (supersaturated calcium phosphate rinse)	❑ **Salivate Rx** (supersaturated calcium phosphate rinse)	

DRUG INFORMATION: Complete information below or authorization will be delayed if incomplete.

Drug Form/Strength: _____

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

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

Note: If approved, a maximum of 120 unit doses per 30 days for supersaturated calcium phosphate rinses or 1 unit (40mL) of Aquoral® per 30 days will be authorized

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

For Mucositis Indication: Please check all that apply (two boxes must be checked)

- ❑ Trial and failure of Magic Mouthwash for 30 days (must be verified by pharmacy paid claims)

AND

- ❑ Trial and failure of lidocaine 2% viscous solution for 30 days (must be verified by pharmacy paid claims)

OR

- ❑ Trial and failure of Biotene Dry Mouth Moisturizing Spray, Biotene Dry Mouth Oral Rinse or Biotene Moisturizing Oral Rinse for 30 days

For Xerostomia or Hyposalivation Indications: Please check all that apply (one box must be checked)

- ❑ Trial and failure of Mouth Kote® solution for 30 days (must be verified by pharmacy paid claims)

OR

- ❑ Trial and failure of Biotene Dry Mouth Moisturizing Spray, Biotene Dry Mouth Oral Rinse or Biotene Moisturizing Oral Rinse for 30 days

(Continued on next page; signature page MUST be attached to this request form)

(Signature page MUST be included with request form)

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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 8/25/2016
REVISED/UPDATED: ~~11/14/2016; 12/12/2016; 8/17/2017;~~ **(Reformatted) 6/21/2019**