

# 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:** Select one below: PPI Drugs (Non-Preferred)

<input type="checkbox"/> <b>Dexilant®</b> (dexlansoprazole)	<input type="checkbox"/> <b>omeprazole/sodium bicarbonate capsules</b> (generic Zegerid®)	<input type="checkbox"/> <b>omeprazole/sodium bicarbonate powder packets</b> (generic Zegerid®)
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**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/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.

- ☐ Member has tried and failed **30 day trials** of **four (4) generic PPIs** from the following:
  - ☐ esomeprazole 20 or 40mg
  - ☐ lansoprazole 15 or 30mg
  - ☐ omeprazole 10, 20 or 40mg
  - ☐ pantoprazole 20mg or 40mg
  - ☐ rabeprazole 20mg

Member will be required to try the prior drug therapy for a time period of **30 days** before moving to the requested step-edit drug.

*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:**

**\*REVISED/UPDATED:** 10/26/2010; 6/2/2011; 6/14/2011; 6/16/2011; 9/16/2011; 10/5/2011; 10/25/2011; 2/16/2012; 2/29/2012; 7/1/2012; 8/16/2012; 7/13/2013; 3/20/2014; 11/20/2014; 12/30/2014; 5/22/2015; 6/18/2015; 11/19/2015; 12/28/2015; 2/9/2016; 3/22/2016; 3/30/2016; 6/22/2016; 10/1/2016; 12/19/2016; 8/16/2017; 11/24/2017; 1/23/2018; 3/31/2018; (Reformatted) 6/19/2019; 3/17/2022; **3/25/2022**