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: Ophthalmic Antihistamine/Ophthalmic Allergy (select one below)

❑ **Alocril®** (nedocromil sodium ophthalmic solution 2%)	❑ **Alomide®** (lodoxamide tromethamine ophthalmic solution 0.1%)	❑ **bepotastine besilate ophthalmic solution 1.5%** (Bepreve®)
❑ **Lastacaft®** (alcaftadine ophthalmic solution 0.25%)	❑ **Zerviate™** (cetirizine)	

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.

If requesting Alocril, bepotastine, Lastacaft or Zerviate:

- ❑ Patient must have documentation of trial and failure of **THREE (3)** of the following **(check each that has been tried; trials will be verified through paid pharmacy claims or chart notes)**:
  - ❑ ketotifen 0.025% ophthalmic solution
  - ❑ azelastine 0.05% ophthalmic solution
  - ❑ cromolyn sodium 4% ophthalmic solution
  - ❑ epinastine 0.05% ophthalmic solution
  - ❑ olopatadine 0.1% ophthalmic solution
  - ❑ olopatadine 0.2% ophthalmic solution

If requesting Alomide:

- ❑ Patient must have documentation of trial and failure of cromolyn sodium 4% ophthalmic solution **(trials will be verified through paid pharmacy claims or chart notes)**

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 6/8/2021
REVISED/UPDATED: ~~6/30/2013; 3/20/2014; 11/2/2014; 5/21/2015~~; ~~8/3/2015~~; ~~8/26/2015~~; ~~12/28/2015;~~ ~~12/19/2016~~; ~~8/15/2017~~; ~~10/10/2018;~~ ~~12/20/2018~~; ~~(Reformatted) 6/19/2019;~~ ~~6/15/2020;~~ ~~9/15/2021;~~ **10/8/2021**;