## **OPTIMA HEALTH PLAN**

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

<u>Directions</u>: <u>The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request</u>. All other information may be filled in by office staff; <u>1-800-750-9692</u>. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. <u>If the information provided is not complete, correct, or legible, the authorization process can be delayed.</u>

**<u>Drug Requested</u>**: **Crinone**<sup>®</sup> (progesterone vaginal gel)

<b>DRUG INFORMATION:</b> Authorization	may be delayed if incomplete.
Drug Form/Strength:	
Dosing Schedule:	
Diagnosis:	ICD Code, if applicable:
Infertility uses are <b>EXCLUDED</b> .	
	all that apply. All criteria must be met for approval. To support g lab results, diagnostics, and/or chart notes, must be provided
☐ Member is pregnant and requires the us <b>positive pregnancy test.</b> (Authorization	se of Crinone <sup>®</sup> until placental autonomy. Submit results of ion is for 12 weeks.)
OR	
☐ Member has secondary physiologic am	enorrhea. (Authorization is for 6 doses of Crinone® 4 %.)
OR	
☐ Member has secondary physiologic ame (Authorization is for 6 doses of Crino	enorrhea and was unresponsive to 6 doses of Crinone <sup>®</sup> 4%.
Medication being provided by Special	ty Pharmacy - PropriumRx
**Use of samples to initiate therapy	value de la value
*Previous therapies will be verified th	rough pharmacy paid claims or submitted chart notes.
Member Name:	
Member Optima #:	
Prescriber Name:	
Prescriber Signature:	Date:
Office Contact Name:	
Phone Number:	
DEA OR NPI #:	
	/20/2014 12/27/2015; 8/12/2016; 9/22/2016; 12/11/2016; 8/3/2017; <b>(Reformatted) 9/6/2019</b> ,