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.**

Drug Requested: Topical Immunomodulators (check applicable box below)

❑ **Zyclara®** (imiquimod) **2.5% Pump:** 1 pump per 28 day fill; 2 fills per year	❑ **Zyclara®** (imiquimod) **3.75% Packets/Pump:** 1 pump/box per 28 day fill; 2 fills per year
❑ **imiquimod 3.75% packets/pump:** 1 pump/box per 28 day fill; 2 fills per year	❑ **Picato®** (ingenol mebutate) **0.015%/0.05% gel:** 1 box per 30 day fill; 2 fills per year
❑ **Klisyri® (tirbanibulin) 1% ointment:** 1 box per year	

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 Actinic Keratosis:

- ❑ Requested product:
  - ❑ Klisyri® 1% ointment
  - ❑ Picato® gel
  - ❑ Zyclara® 2.5% or 3.75% pump/packets
  - ❑ imiquimod 3.75% packets/pump
- ❑ Patient has a diagnosis of Actinic Keratosis
- ❑ Patient has had a 30 day trial and inadequate response or clinically significant adverse reaction to two of the following medications: **(Chart notes must be submitted)**
  - ❑ imiquimod (generic Aladara) 5% cream; QL = 48 packets per year
  - ❑ Topical diclofenac (generic Solaraze) 3% gel; QL= 100 gm per year
  - ❑ Topical 5-fluoruracil 5 % cream, 2 % solution or 5% solution; QL= 10 mL or 40 gm per year

For External Genital and Perianal Warts/Condyloma Acuminata:

- ❑ Requested Product:
  - ❑ Zyclara® 3.75% Packets/Pump
- ❑ Patient has a diagnosis of external genital and/or perianal warts/condylomata acuminata

AND

- ❑ Patient has a documented trial and inadequate response or clinically significant adverse reaction to imiquimod 5% cream **(Chart notes must be submitted)**

OR

- ❑ Patient has a documented trial and inadequate response or clinically significant adverse reaction to topical podofilox **(Chart notes must be submitted)**

(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**: 8/20/2015
REVISED/UPDATED: ~~10/23/2015; 12/22/2015~~; ~~12/20/2016; 8/19/2017;~~ ~~(Reformatted) 6/19/2019~~; 1/22/2020; **6/30/2021**;