OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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.**

Proton Pump Inhibitors (PPI) Drugs

Drug Requested: (check box below that applies)

PREFERRED PPIs			
❑ **omeprazole RX**		❑ **pantoprazole tablets**	
❑ **Protonix® suspension**		❑ **pantoprazole suspension**	
Non-Preferred PPIs			
❑ Aciphex® DR tab/sprinkle	❑ Dexilant® and generic dexlansoprazole DR	❑ esomeprazole magnesium	❑ esomeprazole strontium
❑ lansoprazole cap	❑ Nexium®	❑ Omeprazole OTC	❑ omeprazole magnesium OTC
❑ omeprazole/sodium bicarbonate	❑ Prevacid® RX, OTC, & Solutab	❑ rabeprazole DR tab	❑ Prilosec® RX & Susp
❑ Protonix® tablets	❑ Zegerid® cap, OTC, susp packet		

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.

(Continued on next page)

1. Request type: ❑ Initial Request ❑ Renewal Request

   NOTE: PDL Criteria must be met first before a non-preferred PPI may be approved.

   Initial requests - may be authorized for 12 weeks only.

   Renewal requests – for both **Preferred** and **non-preferred** PPI usage for greater than 3 months may be allowed for 1 year **ONLY** if one of the following exceptions has been met:

   Member is under the care of a Gastroenterologist **OR** member has a diagnosis of **ACTIVE** GI Bleed, Erosive Esophagitis, Gastroesophageal Reflux Disease, Pathological Hypersecretory Syndrome, Unhealed Gastric, Duodenal or Peptic Ulcer, Barrett's Esophagus or Zollinger-Ellison Syndrome.

2. Has member had a therapeutic failure of no less than a **3-month trial** of at least **TWO Preferred** PPIs*?*

   ❑ Yes ❑ No

   a. If **YES**, list medications.

   Drug 1: _____ Strength: _____ Date: _____

   Drug 2: _____ Strength: _____ Date: _____

   Drug 3: _____ Strength: _____ Date: _____

   b. If **NO**, document compelling details.

   _____

   _____

   _____

   _____

3. Has member seen a Gastroenterologist?

   ❑ Yes ❑ No

   If **YES**, document name: _____

4. Does member have one of the following conditions?

   a. GI Bleeds ❑ Yes ❑ No
   b. Zollinger-Ellison Syndrome ❑ Yes ❑ No
   c. Gastroesophageal Reflux Disease GI Bleeds ❑ Yes ❑ No
   d. Pathological Hypersecretory Syndrome ❑ Yes ❑ No
   e. Unhealed Gastric, Duodenal or Peptic Ulcer GI Bleeds ❑ Yes ❑ No
   f. Barrett's Esophagus ❑ Yes ❑ No
   g. Erosive Esophagitis ❑ Yes ❑ No

Medical Necessity (provide clinical evidence that the Preferred drug(s) will not provide adequate benefit):

_____

_____

_____

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

(Please ensure signature page is attached to 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.*

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~6/30/2017; 8/4/2017; 8/31/2017; 8/29/2018; 10/24/2018; 3/13/2019; 3/31/2019; 12/7/2019, 12/09/2021;~~ **7/8/2022**