

# 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; **(Pharmacy) 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 can be delayed.

**Drug Requested:** Lyrica® CR (pregabalin)

**DRUG INFORMATION:** Complete information below or authorization will 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. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

- ☐ Patient must have documentation of at least a 30-day trial and failure of immediate release pregabalin (Lyrica®).

**\*\*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:**

**UPDATED/REVISED:** 9/20/2018; (Reformatted) 6/19/2019