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: Topical Antibiotics

❑ **Altabax®** (retapamulin) **1% ointment**	❑ **Xepi™** (ozenoxacin) **1% cream**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Quantity Limits: 30 grams per prescription

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.

- ❑ Member meets **ONE** of the following age requirements for use:
  - ❑ If requesting Altabax, member is 9 months of age or older
  - ❑ If requesting Xepi, member is 2 months of age or older
- ❑ Member has a diagnosis of impetigo with clinical documentation of **ONE** of the following infections:
  - ❑ Staphylococcus aureus
  - ❑ Streptococcus pyogenes
- ❑ Member has tried and failed, has a contraindication or intolerance to mupirocin 2% ointment **(verified by chart notes or pharmacy paid claims)**

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**: 3/17/2022
REVISED/UPDATED: ~~3/25/2022; 6/15/2022;~~ **6/16/2022**