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. Incomplete form will delay authorization process.***

Drug Requested: **Compound Drug(s)**

Ingredients:

Drug	Strength	Drug	Strength
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The Compound must contain at least one FDA-approved prescription drug and the prescription ingredients must be in therapeutic amounts recognized by national compendia or peer-reviewed medical literature.

Indication: _____

Dosage form of compound: _____

CLINICAL CRITERIA: Check information below. Information must be met to qualify. If incomplete, authorization process will be delayed.

- ❑ National Compendia reference or two (2) peer-reviewed randomized controlled trials supporting the efficacy and safety of this compound are attached to this request.

AND

- ❑ Patient has tried and failed at least three (3) FDA-approved commercially available therapeutic alternatives and at least one of the alternatives is of the same route of administration as the compound:
  - o **Drug** _____ **Route of administration**: _____
  - o **Drug** _____ **Route of administration**: _____
  - o **Drug** _____ **Route of administration**: _____

AND

- ❑ The strength requested is **not** commercially available

Compounds containing the following must be in the same dosage form as commercially available specific drug products: diclofenac, flurbiprofen, fluticasone, gabapentin, ketamine, ketoprofen, levoceterizine and mometasone.

Compounds used for cosmetic indications are excluded from the benefit and will be denied.

*****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**: 3/19/2015
REVISED/UPDATED: ~~4/15/2015; 5/22/2015~~; ~~12/29/2015~~; ~~12/15/2016~~; **8/8/2017**