# OPTIMUM HEALTHCARE
## MEDICATION THERAPY REVIEW

**INSTRUCTIONS:**

- **PLEASE FAX THE COMPLETED PRIOR AUTHORIZATION/STEP THERAPY REQUEST TO THE PHARMACY DEPARTMENT VIA FAX number: (1-844-430-1704)**
- **NOTE: ANY MEMBER OF THE PHYSICIAN'S STAFF MAY COMMUNICATE THIS INFORMATION TO OPTIMUM HEALTHCARE. FOR AN EXPEDITED REQUEST CALL BY PHONE: (1-833-272-9773)**

### PATIENT INFORMATION

**LAST NAME:** **FIRST NAME:** **MI:**

**PATIENT ID NUMBER:**

**DATE OF BIRTH:**

**PHARMACY:** **PHARMACY PHONE:**

### DRUG REQUESTED

**NAME:** **STRENGTH:** **QUANTITY:** **DURATION OF THERAPY:**

**1. HAS THIS PATIENT PREVIOUSLY RECEIVED THIS DRUG?** ☐ **YES** ☐ **NO IF YES, HOW LONG?** _____

**START DATE:** _____

**2. HAS PATIENT HAD A DOCUMENTED ALLERGY/INTOLERANCE TO SIMILAR FORMULARY MEDICATIONS?**

☐ **YES** ☐ **NO** ☐ **N/A**

**3. LIST THERAPY FAILURE ON ONE OR MORE FORMULARY DRUGS WITHIN THE SAME THERAPEUTIC CLASS:**

**4. PATIENT DIAGNOSIS:**

***Please include all relevant documentation, including the most recent tests, procedures, prior therapies tried and failed, etc., to support your request for this drug.***

**It is important that the following information is filled in completely in order to successfully process your request.**

**PHYSICIAN NAME:** **PHYSICIAN PHONE #**

**FIRST:** **LAST:**

**NPI:** **SPECIALTY:** **DATE:**

**ADDRESS:**

**PHYSICIAN FAX: # (FOR FAXED NOTIFICATION):** **CONTACT:**