OPTIMA HEALTH MANAGEMENT

OUTPATIENT PHARMACY STEP-EDIT REQUEST FORM*

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 and faxed to 757-552-7516 or 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.

Step Therapy Required For:

Avapro/Avalide (ibesartan)

Preferred ARBs: Cozaar, Hyzaar

1. What medication are you requesting? ____

2. Has the patient previously tried and failed a generic ACEI? ☐ Yes ☐ No

3. Has the patient previously tried and failed Cozaar or Hyzaar? ☐ Yes ☐ No

4. Is the patient currently stable on the requested medication? ☐ Yes ☐ No

   Please note: Use of samples to initiate therapy does not meet step-therapy criteria.

5. Please include any additional information that should be considered for review of this request

   ____

Patient ________________________________ Member Number ________________________

Physician Signature _______________________________________Date_________________

Physician Name _____________________________________Phone Number __________________

Physician Fax Number _____________________________

Pharmacy Name______________________________ Pharmacy Tel # ____________________(If available)

*Updated 5-27-09