

# 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:

#### Azor (olmesartan/amlodipine)

**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