

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:

Cozaar/Hyzaar (losartan)

1. Has the patient previously tried and failed a **generic** ACE-I? Yes No

If yes, please list all ACE-I tried _____

2. 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.

3. 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)