

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:

Diovan/Diovan HCT (valsartan)

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