OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

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; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.***

Drug Requested: **Zontivity®** (vorapaxar) ***(Non-Preferred)*** ***(MEDICAID)***

DRUG INFORMATION: ***Complete information below. If incomplete, authorization process will be delayed.***

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

CLINICAL CRITERIA: ***The following criteria must be met or authorization will be delayed.***

- ❑ Prescriber is a cardiologist or in consultation with a cardiologist ❑ Yes ❑ No

AND

- ❑ Patient is ≥ 18 years of age;

AND

- ❑ Diagnosis of myocardial infarction (MI) or peripheral arterial disease (PAD)

AND

- ❑ Patient must not have a history of stroke, TIA, ICH, GI bleed and peptic ulcer;

AND

- ❑ Patient must have concomitant therapy with clopidogrel, unless they have a contraindication to clopidogrel in which case patient must have concomitant therapy with aspirin;

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018