OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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.**

Phosphodiesterase 5 Inhibitors (PDE-5) Medications

Drug Requested (please check applicable box below):

❑ **Adcirca® (preferred)**	❑ **Revatio®** (tab/sus/injection) **(non-preferred)**
❑ **sildenafil tab (preferred)**	

DRUG INFORMATON: Complete information below or authorization process will be delayed.

Drug Name/Form/Strength: _____

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

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

CLINICAL CRITERIA: The following criteria **must** be met. Chart notes **MUST** be included or authorization will be delayed.

❑ **Prescriber is**: ❑ Pulmonologist **OR** ❑ Cardiologist

AND

❑ Clinical diagnosis of pulmonary arterial hypertension

AND

❑ Member is > 18 years

AND

❑ Trial and failure of sildenafil and Adcirca® **if requesting** Revatio® tablets

❑ Trial and failure of oral Revatio® **in requesting** injectable Revatio®

❑ Clinical rationale for **NOT** taking oral Revatio® in requesting authorization for injectable Revatio **(Attach chart notes/medical notes)**

_____

_____

_____

_____

(continued on next page; signature **MUST** be attached to this request.)

(Signature page **MUST** be attached to this request.)

Medication being provided by a Specialty Pharmacy: PropriumRx

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: ~~6/30/2017;~~ ~~8/26/2017;~~ **8/15/2018**;