

**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.**

Drug Requested: **Entresto® (sacubitril/valsartan) (Preferred)**

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

Drug Form/Strength: _____

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

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

Quantity Limit: **2 per day**

CLINICAL INFORMATION: The following criteria **must** be met to ensure authorization will **NOT** be delayed.

- Patient has diagnosis of chronic heart failure (NYHA Class II-IV), **AND**
- Must be \geq 18 years, **AND**
- Left ventricular ejection fraction \leq 40%

****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; 9/2/2017; 8/18/2018; 11/21/2018