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: **Savaysa**® (edoxaban) **(Non-Preferred)**

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

Drug Form/Strength: ____________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________________

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

CLINICAL CRITERIA: The following criteria **MUST** be met to qualify to ensure authorization will **NOT** be delayed**.**

- ❑ Diagnosis of:
  - ❑ Non-valvular Atrial Fibrillation,

    OR
  - ❑ Deep vein thrombosis,

    OR
  - ❑ Pulmonary embolism,

    AND
- ❑ Documentation that CrC1 is **NOT** ≥ 95mL/min calculated by Cockcroft-Gault equation

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~~; ~~8/31/2017~~; **8/29/2018**