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: **Zontivity®** (vorapaxar) **(Non-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:** _____

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

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

AND

- ❑ Patient is ≥ 18 years of age; ❑ Yes ❑ No

AND

- ❑ Diagnosis of myocardial infarction (MI) or peripheral arterial disease (PAD) ❑ Yes ❑ No

AND

- ❑ Patient must not have a history of stroke, TIA, ICH, GI bleed and peptic ulcer; ❑ Yes ❑ No

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; ❑ Yes ❑ No

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; 9/1/2017;~~ **9/1/2018**