

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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: (please check applicable box below) (MEDICAID)

Phosphodiesterase 5 Inhibitors (PDE-5)

<input type="checkbox"/> Adcirca® (preferred)	<input type="checkbox"/> sildenafil tab (preferred)
<input type="checkbox"/> Revatio® (tab/sus/injection) (non-preferred)	

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

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*)

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 #: _____