# 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:** **Zontivity®** (vorapaxar) ***(Non-Preferred)*** ***MEDICAID***

***DRUG INFORMATION: Complete information below. If incomplete, 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 or authorization will be delayed.***

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

**AND**

- ❑ Patient is ≥ 18 years of age;

**AND**

- ❑ Diagnosis of myocardial infarction (MI) or peripheral arterial disease (PAD)

**AND**

- ❑ Patient must not have a history of stroke, TIA, ICH, GI bleed and peptic ulcer;

**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;

***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**