

OPTIMA HEALTH PLAN

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 form will delay authorization process.*

Drug Requested: **Adcirca®** (tadalafil)

DRUG INFORMATION: Complete information below. Lines not completed will delay authorization process.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: ALL lines below must be completed to qualify. Authorization process will be delayed if incomplete.

- Prescriber is a pulmonologist
- Clinical diagnosis of pulmonary arterial hypertension WHO group I
- Must be supported by documentation from medical records
- Not receiving organic nitrates either regularly or intermittently due to potentiation of the hypotensive effects
- Must have tried and failed Revatio® (sildenafil citrate)**

Medication being provided by a Specialty Pharmacy: Briova SpecialtyRx

****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 #: _____

*Approved by Pharmacy and Therapeutics Committee: 1/21/2010

UPDATED: 6/6/2011; 8/11/2011; 4/8/2014; 8/8/2014; 9/23/2014; 11/6/2014; 5/21/2015; 12/24/2015; 4/21/2016; 5/4/2016; 8/8/2016; 9/20/2016; 11/16/2016; 12/12/2016; 9/11/2017; 10/6/2017