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 (*select one from below*):

❑ **Amturnide**® (amlodipine, aliskiren, and HCTZ)	❑ **Tekamlo**® (aliskiren and amlodipine)
❑ **Azor**® (amlodipine and olmesartan	❑ **Tekturna**® (aliskiren)
❑ **Benicar**® (olmesartan)	❑ **Tekturna**® **HCT** (aliskiren)
❑ **Benicar**® **HCT** (olmesartan)	❑ **Teveten**® **HCT** (eprosartan mesylate);
❑ **Tribenzor**® (olmesartan medoxomil, amlodipine and HCTZ)	

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

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

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

CLINICAL CRITERIA: *The following criteria MUST be met. Check ALL boxes that apply. If not checked, authorization process will be delayed.*

❑ Patient has tried and failed therapy with ***at least one*** of the following ***(select one):***

❑ amlodipine and valsartan	❑ eprosartan	❑ amlodipine, valsartan, and HCTZ
❑ losartan	❑ losartan HCTZ	❑ candesartan
❑ candesartan HCTZ	❑ irbesartan	❑ irbesartan HCTZ
❑ valsartan	❑ valsartan HCTZ	❑ telmisartan
❑ telmisartan HCTZ	❑ telmisartan amlodipine	

AND

❑ Patient has tried and failed therapy with Edarbi® or Edarbyclor®

Member will be required to try the prior-therapy drug for a time period of 30 days before moving to the requested step-edit drug.

*****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 #: _____ Member Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Phone Number: _____ Fax Number: _____

DEA/NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 1/21/2010
REVISED/UPDATED: ~~1/20/2011; 9/06/20011; 10/25/2011; 7/1/2012; 1/10/2013; 5/21/2013; 3/20/2014; 8/6/2014; 10/30/2014; 2/9/2015; 5/21/2015; 12/27/2015; 12/15/2016;~~ **9/19/2017**