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: *(Insomnia Drug)* ❑ **Zolpimist™** (zolpidem)

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 below criteria MUST be met to qualify or authorization process will be delayed.

❑ Patient has tried and failed ***at least 30 days*** of ***two (2)*** of the following medications:

❑ zolpidem or zolpidem CR	❑ temazepam
❑ zaleplon	❑ eszopiclone

*****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**: 1/21/2011
UPDATED/REVISED: ~~3/30/2011; 8/18/2011; 2/16/2012; 4/19/2012; 5/25/2012; 7/2/2012; 3/20/2014; 5/15/2014; 10/31/2014; 1/15/2015; 1/26/2015; 5/21/2015; 12/28/2015; 12/19/2016; 1/19/2017~~; **9/21/2017**;