

# 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.*

**Drug Requested:**                    Ocular Prostaglandin Analogues

- bimatoprost ophthalmic solution (generic for Lumigan®)

**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:** Applicable boxes below **must** be checked to qualify or authorization process will be delayed.

- Member has tried **ONE (1)** of the following (*check each drug tried*):
  - latanoprost (generic for Xalatan®)
  - travoprost (generic for Travatan Z®)

**\*\*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: 4/18/2013

REVISED/UPDATED: 6/30/2013; 3/20/2014; 11/2/2014; 4/17/2015; 5/22/2015; 12/28/2015; 12/19/2016; 2/2/2017; 2/9/2017; 9/22/2017