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 applicable drug*): ***(Overactive Bladder)***

- ❑ darifenacin (generic **Enablex**®)

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*: *ALL appropriate boxes must be checked to qualify or authorization process will be delayed.

- Patient must have documentation of **at least a *30-day*** trial and failure of ***TWO (2)*** of the following ***(check each that have been tried)*:**

❑ oxybutynin	❑ oxybutynin ER
❑ tolterodine	❑ tolterodine ER
❑ trospium	❑ trospium ER
❑ Oxytrol® for Women	

*****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**: 4/17/2014
REVISED/UPDATED: ~~5/8/2014; 5/28/2014; 11/2/2014; 5/22/2015; 12/28/2015; 12/31/2016; 1/19/2017;~~ **9/22/2017**