OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION 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; faxed 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: Zontivity® (vorapaxar)

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

Drug Form/Strength: _____

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

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

Zontivity® is not to be used as monotherapy

CLINICAL CRITERIA*: *Boxes MUST be checked below to qualify or authorization process will be delayed. Chart notes documenting indication and prior or concomitant therapies tried MUST be attached to this request.

- **Prescriber is**: ❑ **vascular specialist** ❑ **cardiologist**

❑ Has patient had a myocardial infarction? (MI) ❑ Yes ❑ No

1. Does patient have peripheral arterial disease? (PAD) ❑ Yes ❑ No
2. Has patient had a previous stroke? ❑ Yes ❑ No
3. Has patient had a previous transient ischemic attack? (TIA) ❑ Yes ❑ No
4. Has patient had a previous intracranial hemorrhage? ❑ Yes ❑ No

Please submit chart notes documenting indication and prior or concomitant therapies tried

****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**: 9/18/2014
REVISED/UPDATED: ~~11/24/2014; 12/12/2014; 5/22/2015; 12/29/2015; 12/20/2016;~~ **9/24/2017**;