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. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Drug Requested (select one below): Non-Preferred

❑ **Proventil® HFA** (albuterol sulfate)	❑ **Xopenex HFA®** (levalbuterol tartrate)
❑ **albuterol HFA** (generic Ventolin® HFA)	❑ **albuterol HFA** (generic ProAir® HFA)

NOTE: ProAir® (HFA and RespiClick) and Ventolin® HFA is Optima's Preferred Inhaler

DRUG INFORMATION: Complete all information below or authorization will be delayed.

Drug Strength: _____

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

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

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including labs or chart notes **(when required)**, **must** be provided or request will be denied.

❑ Trial and failure of **TWO (2)** of the following:

❑ ProAir® HFA or RespiClick (albuterol sulfate)	❑ Ventolin® HFA (albuterol sulfate)

❑ Patient must have tried and failed **at least 30-days** of therapy

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:** 3/21/2019
REVISED/UPDATED: 3/29/2019