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 one)*:

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

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

- ❑ Patient is ≥ 4 years of age
- ❑ Patient tried and failed Ventolin HFA

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

*****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 the Pharmacy and Therapeutics Committee**: 8/21/2014
REVISED/UPDATED: ~~9/29/2014; 11/5/2014; 1/16/2015; 5/21/2015; 12/28/2015; 12/19/2016;~~ **8/14/2017**