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

Long-Acting Beta2 Agonist (LABA) and Inhaled Corticosteroid (ICS) Combination Products

Drug Requested - Select one from below**:**

❑ **Dulera**® (mometasone and formoterol)	❑ **AirDuo RespiClick**® (fluticasone and salmeterol)

DRUG INFORMATION: Complete 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 (if required), **must** be submitted or request will be denied.

Diagnosis: Asthma

❑ Patient must be ≥ 12 years of age

AND

❑ Patient must have tried and failed **at least 30 days** of **all** three (3) of the following:

❑ Advair®	**AND**	❑ Breo® Ellipta®	**AND**	❑ Symbicort®

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:** ~~10/19/2017;~~ 2/21/2019
REVISED/UPDATED: ~~12/12/2017;~~ **3/2/2019**