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 from below):*

❑ **Amturnide**® (amlodipine, aliskiren, and HCTZ)	❑ **Tekamlo**® (aliskiren and amlodipine)
❑ **Azor**® (amlodipine and olmesartan)	❑ **Tekturna**® (aliskiren)
❑ **Benicar**® (olmesartan)	❑ **Tekturna**® **HCT** (aliskiren)
❑ **Benicar**® **HCT**(olmesartan)	❑ **Teveten**® **HCT** (eprosartan mesylate);
❑ **Tribenzor**® (olmesartan medoxomil, amlodipine and HCTZ)	

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

Drug Name/Form/Strength: ____

Dosing Schedule: ______________________________ **Length of Therapy**: ____________________

Diagnosis: __________________________________ ***ICD Code, if applicable***: ________________

***CLINICAL CRITERIA**: The following criteria **MUST** be met. Check **ALL** boxes that apply. If not checked, authorization process will be delayed.*

- ❑ Patient has tried and failed therapy with ***at least one*** of the following ***(select one)***:
  - ❑ amlodipine and valsartan
  - ❑ amlodipine, valsartan, and HCTZ
  - ❑ losartan HCTZ
  - ❑ irbesartan
  - ❑ irbesartan HCTZ
  - ❑ valsartan
  - ❑ valsartan HCTZ
  - ❑ eprosartan
  - ❑ losartan
  - ❑ candesartan
  - ❑ candesartan HCTZ
  - ❑ telmisartan
  - ❑ telmisartan HCTZ
  - ❑ telmisartan amlodipine

AND

- ❑ Patient has tried and failed therapy with Edarbi® or Edarbyclor®

Member will be required to try the prior-therapy drug for a time period of 30 days before moving to the requested step-edit drug.

*****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**: 1/21/2010
REVISED/UPDATED: ~~1/20/2011; 9/06/20011; 10/25/2011; 7/1/2012; 1/10/2013; 5/21/2013; 3/20/2014; 8/6/2014; 10/30/2014~~; ~~2/9/2015~~; ~~5/21/2015~~; ~~12/27/2015~~; ~~12/15/2016~~; **8/9/2017**;