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: **Bystolic**™ (nebivolol)

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***: ______________

CLINICAL CRITERIA: The following MUST be met to qualify or authorization process will be delayed.

- Patient has tried and failed therapy with ***at least one (1)*** of the following:

❑ atenolol	❑ bisoprolol
❑ carvedilol	❑ metoprolol

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

*****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:** 10/17/2015
REVISED/UPDATED: ~~10/29/2015~~; ~~12/30/2015~~; ~~12/15/2016~~; **8/9/2017**;