

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: Dulera® (mometasone furoate and formoterol fumarate dehydrate)

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 criteria **MUST** be met. **ALL** boxes **must** be checked to qualify or authorization process will be delayed.

DIAGNOSIS: Asthma

- Patient is ≥ 12 years of age
- Trial and failure of all three (3) of the following:

<input type="checkbox"/> Advair®	AND	<input type="checkbox"/> Breo® Ellipta®	AND	<input type="checkbox"/> Symbicort®
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- 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 the Pharmacy and Therapeutics Committee: 10/19/2017
REVISED/UPDATED: 12/12/2017