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 below*):

❑ **Edarbi®** (azilsartan)	❑ **Edarbyclor®** (azilsartan and chlorthalidone)

***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***: _____

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

CLINICAL CRITERIA*: *Boxes MUST be checked below to qualify or authorization process will be delayed.

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

❑ amlodipine valsartan	❑ amlodipine valsartan HCTZ	❑ losartan
❑ losartan HCTZ	❑ irbesartan	❑ irbesartan HCTZ
❑ valsartan	❑ valsartan HCTZ	❑ eprosartan
❑ candesartan	❑ candesartan HCTZ	❑ telmisartan
❑ telmisartan HCTZ	❑ telmisartan amlodipine	

****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 on:** 11/19/2012

***REVISED/UPDATED:** ~~1/10/2013; 8/4/14; 8/5/2014; 10/30/2014; 5/21/2015;~~ 12/27/2015; ~~1/19/2016; 12/16/2016;~~ **8/12/2017**;