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: **Livalo®** (pitavastatin)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable**: _____

CLINICAL CRITERIA: ALL boxes **must** be checked to qualify or authorization will be delayed.

- ❑ Patient failed to reach LDL-cholesterol goals with a trial of **ONE** of the following: pravastatin, atorvastatin, rosuvastatin, fluvastatin, simvastatin, or simvastatin-ezetimibe for **30 days**.
- ❑ **Patient initiated therapy while covered under another insurance plan and recently converted to Sentara/Optima coverage (subject to verification by Sentara/Optima).**

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 Therapeutic Committee:**
REVISED/UPDATED: ~~1/20/11; 3/30/2011; 6/14/2011; 8/22/2011; 9/13/2011; 12/1/2011; 7/2/2012; 7/17/2012; 8/17/2012; 10/11/2012; 10/17/2013; 11/20/2013; 11/6/2014; 5/22/2015; 12/23/2015; 12/20/2016; 8/23/2017;~~ **2/15/2019**