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: Lonhala Magnair® (glycopyrrolate) **oral inhalation solution**

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

Drug Form/Strength: _____

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

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

Quantity limit: 60 vials/30days

CLINICAL CRITERIA: The following criteria **MUST** be met. **ALL** boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed.

- ❑ Patient has at **least 30 days** treatment failure or contraindication to **BOTH** of the following:
  - ❑ Spiriva® Handihaler®

    OR
  - ❑ Spiriva® Respimat®

    AND
  - ❑ Incruse® Ellipta®

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:** 6/21/2018
REVISED/UPDATED: 9/24/2018