

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): *Ocular Prostaglandin Analogues*

Lumigan® (bimatoprost ophthalmic solution)

Zioptan® (tafluprost ophthalmic solution)

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: _____

CLINICAL CRITERIA: Applicable boxes below **must** be checked to qualify or authorization process will be delayed.

• Member has tried **ONE (1)** of the following (*check each drug tried*):

latanoprost (Xalatan®)

travoprost (Travatan Z®)

****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: 4/18/2013

REVISED/UPDATED: 6/30/2013; 3/20/2014; 11/2/2014; 4/17/2015; 5/22/2015; 12/28/2015; 12/19/2016; 8/15/2017