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**

❑ **Vyzulta**™ (latanoprostene bunod ophthalmic solution)	❑ **Zioptan**® (tafluprost ophthalmic solution)
❑ **Rhopressa**® (netasudil)	

DRUG INFORMATION: Complete information below or authorization 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)**:
  - ❑ bimatoprost 0.03%
  - ❑ latanoprost (Xalatan®)
  - ❑ travoprost (Travatan Z®)
  - ❑ Lumigan® (bimatoprost ophthalmic solution) 0.01%

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; 6/16/2018;~~ **10/1/2018**