

# 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:**            **Oleptro™ ER** (trazodone ER)

**DRUG INFORMATION:** Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_            Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_            ICD Code, if applicable: \_\_\_\_\_

**Maximum daily dose should not exceed 375mg**

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

- Patient has tried and failed at least **30 days** of therapy with:
  - trazodone

**\*\*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: 10/21/2010

REVISED/UPDATED: 6/9/2011; 8/22/2011; 4/10/2014; 10/7/2014; 10/8/2014; 11/2/2014; 5/22/2015; 12/28/2015; 12/19/2016; 8/15/2017;