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 applicable drug*): ***Overactive Bladder***

❑ **Enablex®** (darifenacin)	❑ **Gelnique®** (oxybutynin transdermal gel)	❑ **Myrbetriq®** (mirabegron)
❑ **Oxytrol® RX** (oxybutynin transdermal)	❑ **Toviaz®** (fesoterodine)	❑ **VESIcare®** (solifenacin)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Name/Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy**: ______________

Diagnosis: ______________________ ***ICD Code, if applicable***: ______________

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

- Patient must have documentation of **at least a *30-day*** trial and failure of ***TWO (2)*** of the following ***(check each that have been tried)***:

❑ oxybutynin	❑ oxybutynin ER
❑ tolterodine	❑ tolterodine ER
❑ trospium	❑ trospium ER
❑ Oxytrol® for Women	

- Patient initiated therapy with Enablex®, Gelnique®, Myrbetriq®, Oxytrol® RX, Toviaz®, or VesiCare® while covered under another insurance plan and converted to Sentara/Optima coverage ***within the last 60 days*** ***(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 Therapeutics Committee**: 4/17/2014
REVISED/UPDATED: 5/8/2014; 5/28/2014; 11/2/2014; 5/22/2015; 12/28/2015; 12/31/2016; **8/16/2017**