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: **Rapaflo**® (silodosin)

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

Drug Form/Strength: _____

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

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

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

- ❑ Patient has trial and failure of ***30 days*** of therapy with ***TWO (2)*** of the following medications:

❑ alfuzosin	❑ doxazosin
❑ tamsulosin	❑ terazosin

*****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**: 10/15/2015
REVISED/UPDATED: ~~10/23/2015~~; ~~12/22/2015~~; ~~12/19/2016~~; **8/16/2017**