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: **Revatio®** (sildenafil citrate)

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:*** _____

Recommended Dosing:

Tablets:	**20 mg, 3 times day, 4-6 hours apart**
Oral suspension:	**5 mg, 3 times a day, 4-6 hours apart**
Injection:	**2.5 mg or 10 mg, 3 times a day as an intravenous bolus injection**

CLINICAL CRITERIA: Check box below to qualify. If not checked, authorization process will be delayed.

- ❑ Patient has been diagnosed with pulmonary arterial hypertension.

Medication being provided by a Specialty Pharmacy (check applicable box below):

For Optima Commercial Members:

- ❑ **PropriumRx**

For Optima Family Care Members:

- ❑ **Sentara Norfolk General CM Pharmacy**

*****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**: 9/18/2005

REVISED/UPDATED: ~~6/6/2011; 8/31/2011; 8/13/2014; **9/23/2014**; 11/5/2014; 5/22/2015; 12/29/2015; 9/22/2016; 12/11/2016; 8/5/2017;~~ **11/28/2017**