

# 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:** Samsca™ (tolvaptan)

**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 below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed.

Patient has an indication of hypervolemic or euvolemic hyponatremia that has failed to respond to fluid restriction

**AND**

Prescriber is an Endocrinologist or Nephrologist

**AND**

Patient has tried and failed demeclocycline

**\*\*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 the Pharmacy and Therapeutics Committee: 11/19/2009

REVISED/UPDATED: 6/6/2011; 9/7/2011; 10/29/2014; 11/5/2014; 5/22/2015; 12/29/2015; 12/19/2016; 8/17/2017.