

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 one): Statins

<input type="checkbox"/> Livalo® (pitavastatin)	<input type="checkbox"/> Simcor® (simvastatin/niacin)
<input type="checkbox"/> Lescol® (fluvastatin)	<input type="checkbox"/> Vytorin® (simvastatin/ezetimibe)

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: _____

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

- Patient failed to reach LDL-cholesterol goals with a trial of pravastatin, atorvastatin, rosuvastatin or simvastatin for 30 days.
- Patient initiated therapy while covered under another insurance plan and recently converted to Sentara/Optima coverage (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 Therapeutic Committee:

REVISED/UPDATED: 1/20/11; 3/30/2011; 6/14/2011; 8/22/2011; 9/13/2011; 12/4/2011; 7/2/2012; 7/17/2012; 8/17/2012; 10/11/2012; 10/17/2013; 11/20/2013; 11/6/2014; 5/22/2015; 12/23/2015; 12/20/2016 **8/23/2017**