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: **Striverdi Respimat®** (olodaterol)

***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 below *must* be checked to qualify or authorization process will be delayed.**

❑ Patient has been diagnosed with COPD.

AND

❑ Patient has tried and failed Foradil®

AND

❑ Patient has tried and failed Serevent®

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**: 4/17/2015
REVISED/UPDATED: ~~5/27/2015~~; ~~12/29/2015~~; ~~12/20/2016~~; **8/18/2017**