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: **Symbicort** ® (budesonide and formoterol)

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***: _____

Therapy initiated while covered under another insurance and recently converted to Sentara/ Optima is subject to verification.

CLINICAL CRITERIA*: *The following criteria MUST be met. ALL boxes must be checked to qualify or authorization process will be delayed.

Indication: Asthma	**Indication: COPD**
❑ Patient is ≥ 12 years of age ❑ Trial and Failure of Advair **AND** ❑ Trial and Failure of Breo Ellipta **AND** ❑ Trial and Failure of Dulera **Patient has tried and failed at least *30 days* of therapy**	❑ Patient is ≥ 12 years of age ❑ Trial and Failure of Advair **AND** ❑ Trial and Failure of Breo Ellipta **Patient must have tried and failed at least *30 days* of therapy**

*****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**: 10/16/2014
REVISED/UPDATED: ~~10/28/2014~~; ~~11/20/2014~~; ~~12/30/2014~~; ~~5/14/2015~~; ~~5/22/2015~~; ~~12/29/2015~~; ~~12/20/2016~~; **8/18/2017**