OPTIMAHEALTH 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: Trelegy Ellipta® (fluticasone furoate/vilanterol/umeclidinium)

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength:_____

Dosing Schedule: _____ **Length of Therapy**:_____

Diagnosis: _____ ***ICD Code, if applicable*: _____**

*****Maximum Allowed Daily Dose: One inhalation/day.*****

CLINICAL CRITERIA*: *Boxes MUST be checked to qualify or authorization process will be delayed.

- ❑ Patient must be 18 years of age or older

AND

- ❑ Patient must have a diagnosis of chronic obstructive pulmonary disease (COPD)

AND

- ❑ Patient is currently on a fixed dose combination of Breo Ellipta (fluticasone and vilanterol) for airflow obstruction and reducing exacerbations and require additional therapy

OR

- ❑ Patient is currently receiving Incruse Ellipta (umeclidinium) and a fixed-dose combination of Breo Ellipta (fluticasone and vilanterol)

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**: 4/19/2018
REVISED/UPDATED: 6/19/2018