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: **Uptravi®** (selexipag)

***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*: Criteria below *MUST* be met to qualify or authorization process will be delayed. ALL chart notes MUST be attached with this request form.**

- ❑ Prescribed by or in consultation with a pulmonologist or cardiologist
- ❑ Diagnosis of pulmonary arterial hypertension was confirmed by a right heart catheterization
- ❑ Uptravi will not be taken in combination with a prostanoid / prostacyclin analogue
- ❑ History of failure, contraindication, or intolerance to :

ERAs	Date of Utilization	PDE5-Inhibitors	Date of Utilization
Letairis® (ambrisentan)		Revatio® (sildenafil)	
Tracleer® (bosentan)		Adcirca® (tadalafil)	
Opsumit® (macitentan)			

OR

- ❑ Uptravi® will be used in combination with an Endothelin Receptor Antagonist and/ or PDE5 inhibitor

Medication being provided by a Specialty Pharmacy (check applicable box below):

❑ **For Optima Commercial Members:**
PropriumRx

❑ **For Optima Family Care Members:**
Sentara Norfolk General CM Pharmacy

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:** 1/19/2017
REVISED/UPDATED: ~~3/28/2017;~~ **8/23/2017**;