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.***

(OPEN Commercial Formulary ONLY)

***Drug Requested*:** **Vecamyl**® (mecamylamine HCl)

***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***: _____

Recommended dosing: ***start with 50mg once daily at the same time; after two weeks may be increased to 100mg***

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

- ❑ Member ***MUST*** have a diagnosis of hypertension
- ❑ Member ***MUST*** have a documented trial and failure of a combination of three (3) formulary antihypertensive agents from different drug classes, up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are expected
- ❑ Member may ***NOT*** receive concomitant therapy with antibiotics or sulfonamides

*****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**: 10/19/2017
REVISED/UPDATED: ~~12/18/2017;~~ **3/31/2018**;