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: ***(select one below)***

❑ **Auryxia**™ (ferric citrate)	❑ **Velphoro**® (sucroferric oxyhydroxide)
❑ **Fosrenol**® (lanthanum carbonate)	

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: Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed.

❑ Patient has had a ***30 day trial and failure*** of Renvela®

*****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:** 1/21/2016
REVISED/UPDATED: ~~3/30/2016; 12/20/2016;~~ **8/20/2017**;