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. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Duavee® (conjugated estrogens/bazedoxifene)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Recommended Dosage: One Tablet Daily

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is being prescribed medication for **ONE** of the following indications:
  - ❑ Member has a diagnosis of moderate to severe vasomotor menopausal symptoms
  - ❑ Member is at significant risk of osteoporosis
- ❑ Member has tried and failed **30 days of therapy** with **TWO** of the following medications:

❑ alendronate tablets	❑ generic estradiol transdermal patches	❑ Premphase tablets
❑ estradiol tablets	❑ Premarin vaginal cream	❑ Prempro tablets
❑ generic estradiol vaginal cream	❑ Premarin tablets	❑ raloxifene tablets

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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**: ~~3/17/2022~~
REVISED/UPDATED: ~~3/25/2022,~~ **6/14/2022**