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

Long-Acting Antimuscarinic (LAMA) and Long-Acting Beta2 Agonist (LABA) Combination Products

Drug Requested: (Select one from below)

❑ **Bevespi Aerosphere®** (glycopyrrolate and formoterol)	❑ **Breztri®** (budesonide, glycopyrrolate and formoterol)
❑ **Duaklir Pressair®** (aclidinium and formoterol)	❑ **Utibron Neohaler®** (glycopyrrolate and indacterol)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Strength: _____

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

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

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.

Diagnosis: Chronic Obstructive Pulmonary Disease (COPD)

- ❑ Patient must be ≥ 18 years of age
- ❑ Patient must have tried and failed **at least 30 days** of **TWO** of the following:

❑ Anoro Ellipta®	**OR**	❑ Trelegy Ellipta®	**AND**	❑ Stiolto Respimat®

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:** 2/21/2019
REVISED/UPDATED: ~~2/28/2019; 6/3/2020;~~ **11/2/2020**