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.**

Drug Requested (select one below): Non-Preferred Albuterol Inhalers

❑ **albuterol HFA** (generic ProAir® HFA)	❑ **albuterol HFA** (generic Proventil® HFA)
❑ **albuterol HFA** (generic Ventolin® HFA)	❑ **levalbuterol HFA** (generic Xopenex®)
❑ **ProAir® Digihaler/HFA/Respiclick** (albuterol sulfate)	❑ **Proventil® HFA** (albuterol sulfate)

NOTE: Ventolin® HFA is Optima's Preferred Inhaler

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/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.

❑ **For Approval of any Non-Preferred albuterol/levalbuterol inhaler:**

- ❑ Member must have an intolerance or contraindication to Ventolin® HFA (albuterol sulfate)

AND

- ❑ Provider **MUST** submit clinical chart notes or a completed MedWatch form documenting the experienced treatment failure with brand Ventolin® HFA (albuterol sulfate)

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

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.****

Member 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:** ~~3/21/2019;~~ **9/15/2022**
REVISED/UPDATED: ~~3/29/2019; 6/27/2019; 8/13/2019;~~ **10/17/2022**