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 applicable drug): **Overactive Bladder**

❑ **Gemtesa®** (vibegron)	❑ **Myrbetriq®** (mirabegron)	❑ **Toviaz®** (fesoterodine)

DRUG INFORMATION: Complete information below or authorization will be delayed.

Drug Name/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.

- Patient must have documentation of **at least a 30-day** trial and failure of **TWO (2)** of the following **(check each that have been tried):**

❑ oxybutynin IR/ER	❑ darifenacin
❑ tolterodine IR/ER	❑ solifenacin tablets
❑ trospium IR/ER	

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**: 4/17/2014
REVISED/UPDATED: ~~5/8/2014; 5/28/2014; 11/2/2014; 5/22/2015; 12/28/2015; 12/31/2016; 8/16/2017; 2/15/2019; 8/31/2020; 3/8/2021;~~ **6/3/2021**