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:

❑ **Fetzima®** (levomilnacipran)	❑ **Trintellix®** (vortioxetine)
❑ **Viibryd®** (vilazodone)	

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.

❑ Member must have documentation of at least a 30-day trial and failure with either:

- ❑ **TWO** of the following SSRIs

OR

- ❑ **ONE** of the following SSRIs and venlafaxine ER

Check each drug that has been tried. If not checked, authorization process will be delayed.		
❑ citalopram	❑ escitalopram	❑ fluoxetine
❑ paroxetine	❑ sertraline	❑ venlafaxine ER

❑ Member initiated therapy with Trintellix®, Fetzima®, or Viibryd® while covered under another insurance plan and converted to Sentara/Optima coverage **within the last 60 days (subject to verification by Sentara/Optima)**.

(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:**
REVISED/UPDATED: ~~1/2009; 2/21/2011; 6/14/2011; 7/21/2011; 9/12/2011; 2/16/2012; 3/7/2012; 5/25/2012; 7/1/2012; 1/16/2014; 2/10/2014; 2/20/2014; 3/21/2014; 5/7/2014; 10/30/2014; 5/21/2015~~; ~~**12/27/2015**~~; ~~5/3/2016; 5/27/2016; 12/16/2016; 8/13/2017; (Reformatted) 6/11/2019;~~ **8/12/2019**;