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 from below)

❑ **Demser®** (metyrosine)	❑ **Dibenzyline** (phenoxybenzamine)

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 of pheochromocytoma

AND

- ❑ Trial and failure of a selective alpha-blocker (doxazosin, prazosin, terazosin)

AND

- ❑ Trial and failure phenoxybenzamine

AND

- ❑ Resection of the pheochromocytoma is planned or resection of the tumor is contraindicated or has been unsuccessful (documentation of failed surgery or contraindication is required)

AND

- ❑ If requesting brand Demser®, trial and failure of generic metyrosine is required

(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.****

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:** 7/16/2020
REVISED/UPDATED: 11/5/2020