

**PROSTAGLANDIN ANALOG
Step Therapy Request**

Bimatoprost, Travaprost, Travatan Z, and Zioptan (tafluprost)

- Standard Request (72 hours)
 Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information

Prescriber Information

Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested: <input type="checkbox"/> Bimatoprost <input type="checkbox"/> Travaprost <input type="checkbox"/> Travatan Z <input type="checkbox"/> Zioptan (tafluprost)	Strength:	Directions:
Quantity Dispensed:	Day Supply:	<input type="checkbox"/> Generic <input type="checkbox"/> Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.
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Clinical Information

Diagnosis:	Date Diagnosed:
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Has the member previously tried and failed Xalatan (latanoprost)? Yes No

Please provide any additional information which should be considered in the space below:
