Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

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: □ Bimatoprost □ Travaprost □ Travatan Z □ Zioptan (tafluprost)	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

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

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Diagnosis:	Date Diagnosed:

Has the member previously tried and failed Xalatan (latanoprost)? □ Yes □ No

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