

OPTIMA FAMILY CARE MEDALLION 4.0

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: Abstral® (fentanyl)

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

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

- **RECOMMENDED DOSING:** (single 100 mcg tablet)
 - If adequate analgesia is obtained within 30 minutes of administration of the 100 mcg tablet, continue to treat subsequent episodes of breakthrough pain with this dose.
 - If adequate analgesia is **not** obtained after Abstral®, the patient may use a second Abstral® dose (after 30 minutes) as directed by their health care provider. **No more than two doses of Abstral® may be used to treat an episode of breakthrough pain.**

CLINICAL CRITERIA: Check below **ALL** that apply. Boxes **must** be checked to ensure the authorization process will **NOT** be delayed.

- Patient is 18 years or older
 - Patient has breakthrough cancer pain and is opioid tolerant
- AND**
- Member has failed a trial of oral transmucosal fentanyl citrate.
 - Provider has checked information on this patient in the state's Prescription Monitoring Program database.
 - Date PMP database checked: _____

The database check MUST be within the last 90 days.

****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 #: _____