

# 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:**            **Actiq®** (oral transmucosal fentanyl citrate)

**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: \_\_\_\_\_

{Opioid tolerance is defined as taking at least 60 mg morphine/day, 50 mcg transdermal fentanyl/hour or an equianalgesic dose of another opioid for a week or longer.}

**CLINICAL CRITERIA:** ALL boxes must be checked to ensure authorization process will NOT be delayed..

- Member has breakthrough cancer pain and is opioid tolerant  

AND
- Member or caregiver was instructed on disposal of completely or partially used Actiq® units.
- 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 #: \_\_\_\_\_