

# 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:**            **Allzital®** (butalbital/acetaminophen)

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

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

- Patient has tried and failed butalbital/acetaminophen
- 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 #: \_\_\_\_\_

\*REVISED/UPDATED: 7/1/2018