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 (*select one below*): ***Fentanyl Orals***

❑ **Fentora®** (fentanyl buccal tablets),	❑ **Lazanda®** (fentanyl nasal spray)
❑ **Subsys™** (fentanyl sublingual spray)	

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

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable*:** _____

{RECOMMENDED DOSING: Therapy should always be initiated with the lowest strength available. This is 100 mcg for Fentora®, Lazanda® and Subsys™.}

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

- ❑ Patient is ≥ 18 years of age.
- ❑ Member has breakthrough cancer pain and is opioid tolerant.

AND

- ❑ Member has failed a trial of oral transmucosal fentanyl citrate ***(requires a PA).***

AND

- ❑ Member has failed a trial of Abstral® ***(fentanyl sublingual tablets requiring a PA).***
- ❒ **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**