OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)
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 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 qualify for Abstral® or authorization process will 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 #: ______________________________

***REVISED/UPDATED:** ~~8/26/2017; 8/14/2018;~~ **8/14/2018**