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

DRUG INFORMATION: Complete 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 qualify or authorization process will 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 #: _____

***REVISED/UPDATED:** ~~8/26/2017;~~ **8/15/2018**