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 (select **one** from below)**: Fentanyl Orals**	
❑ **Fentora®** (fentanyl buccal tablets),	❑ **Lazanda®** (fentanyl nasal spray)
❑ **Subsys™** (fentanyl sublingual spray)	

DRUG INFORMATION: Complete 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 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.

(continued on next page; signature page **MUST** be attached to this request.)

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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;~~ **8/20/2018**