OPTIMA HEALTH FAMILY CARE
(MEDICAID)
PHARMACY/MEDICAL 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 1-844-723-2094**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Drug Requested: Prialt® (ziconotide) **(J-2278) (Medical)**

❑ **URGENT REVIEW. In checking this box, prescriber attests to the fact that by applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function.**

❑ **STANDARD REVIEW**. In checking this box, the timeframe does **NOT** jeopardize the life or health of the member or the member's ability to regain maximum function and would **NOT** subject the member to severe pain.

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

Drug Form/Strength/Month: ____

Dosing Schedule: ______________________________ **Length of Therapy:** ________________

Diagnosis: ____ **ICD Code:** ____________________

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

- ❑ Prescriber is a pain management specialist.

AND

- ❑ Member does not have a pre-existing history of psychosis.

AND

- ❑ Member has:
  - ❑ Tried and failed other pain therapies including clonidine epidural and Duramorph® epidural.

  OR

  - ❑ History of prior and/or current narcotic abuse

Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

(Continued on next page; signature page MUST be attached to this request form)

(Signature page MUST be included with request)

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.

Member Name: ____

Member Optima #: ________________________ Date of Birth: ______________

Prescriber Name: ____

Prescriber Signature: ________________________ Date: ______________

Office Contact Name: ____

Phone Number: ______________________ Fax Number: ______________

DEA OR NPI #: ____

REVISED/UPDATED: ~~8/1/2017; 9/2/2017; 8/29/2018;~~ **(Reformatted)** ~~5/7/2019;~~ **7/17/2019**