OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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. If incomplete, 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**