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: **Allzital**® (butalbital/acetaminophen)

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***: ______________

CLINICAL CRITERIA: Boxes must be checked to qualify or authorization process will be delayed.

- ❑ Patient has tried and failed butalbital/acetaminophen
- ❑ **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**