OPTIMA HEALTH PLAN

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 1-844-348-3720. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.***

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

DRUG INFORMATON: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength/Month: ____

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

Diagnosis: ____ **ICD Code:** ________________

CLINICAL CRITERIA: Check boxes below. If not completed, authorization process will be delayed.

- ❑ Prescriber is a pain management specialist.

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

  AND
- ❑ Patient 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**

*****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: 8/1/2017; **9/2/2017**;