

OPTIMA HEALTH PLAN

NARCOTICS-REAUTHORIZATION 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.

Drug Requested: (Select one (1) drug) (COMMERCIAL ONLY)

Medical notes must be submitted to support the information provided on this request.

Authorizations are for no more than one year at a time.

<input type="checkbox"/> Abstral®	<input type="checkbox"/> Actiq®	<input type="checkbox"/> Belbuca	<input type="checkbox"/> Butrans®
<input type="checkbox"/> Exalgo®	<input type="checkbox"/> Fentanyl® oral	<input type="checkbox"/> Fentora®	<input type="checkbox"/> Hysingla™ ER
<input type="checkbox"/> Lazanda®	<input type="checkbox"/> Nucynta®	<input type="checkbox"/> Nucynta® ER	<input type="checkbox"/> Opana®
<input type="checkbox"/> Opana® ER	<input type="checkbox"/> Oxaydo	<input type="checkbox"/> Oxecta®	<input type="checkbox"/> OxyContin®
<input type="checkbox"/> Stadol NS®	<input type="checkbox"/> Subsys®	<input type="checkbox"/> Trezix™	<input type="checkbox"/> Xtampza® ER
<input type="checkbox"/> Xartemis® XR	<input type="checkbox"/> Zohydro® ER		

DRUG INFORMATION: All information below **MUST** be completed. If incomplete or boxes are **NOT** checked, outcome of this request may be affected and authorization process will be delayed.

Drug Name/Form: _____ Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Other Medications Currently Used in Combination with the Requested Medication for the Treatment of this Diagnosis:

Narcotics	Benzodiazepines	Other Pain Therapies

Date of last office visit: _____

- Provider has checked information on this patient in the state's Prescription Monitoring Program database **within the last 90 days**. Date PMP database checked: _____ (This **must** be checked.)

*****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 #: _____

*Approved by Pharmacy and Therapeutics Committee: 4/17/2014

REVISED/UPDATED: 5/18/2014; 8/18/2014; 9/5/2014; 9/26/2014; 11/6/2014; 5/22/2015; 6/25/2015; 12/29/2015; 12/8/2016; 12/21/2016; 9/19/2017.