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 1-844-202-5034. 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: **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**: ❑ **Briova SpecialtyRx**

*****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:**
REVISED/UPDATED: ~~6/62011; 8/30/2011; 4/14/2014; 5/13/2014; 10/31/2014; 4/3/2015; 5/23/2015; 12/30/2015; 1/29/2016; 8/18/2016; 9/22/2016; 11/29/2016; 12/13/2016; 9/16/2017;~~ **10/4/2017**.