

# OPTIMA HEALTH PLAN

## PHARMACY/MEDICAL PRIOR AUTHORIZATION 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 INFORMATION:** Complete all information below or authorization process will be delayed.

Drug Form/Strength/Month: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

**CLINICAL CRITERIA:** Check boxes below or authorization could 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: 6/6/2011; 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