OPTIMA HEALTH PLAN

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 1-800-750-9692. 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: **Stadol® Nasal Spray** (butorphanol nasal)

***DRUG INFORMATION:* Complete information below. Authorization process will be delayed if incomplete.**

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable*:** _____

***CLINICAL CRITERIA*: Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed.**

- ❑ Patient has a diagnosis of headaches
- ❑ Patient has tried at least three other rescue and/or abortive medications
- ❑ **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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 12/8/2008
REVISED/UPDATED: ~~6/8/2011; 9/8/2011; 11/5/2014; 5/22/2015; 6/25/2015; 12/29/2015; 12/20/2016;~~ **9/23/2017**