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 *(select one drug)*: *Long-Acting Narcotics* - *(COMMERCIAL ONLY)*

❒ **Arymo™ ER** (morphine sulfate)	❑ **Opana® ER** (oxymorphone controlled-release)
❒ **Belbuca™** (buprenorphine buccal film)	❑ **OxyContin®** (oxycodone controlled-release)
❒ **Butrans Transdermal System®** (buprenorphine)	❑ **Xtampza™ ER** (oxycodone controlled-release)
❑ **Exalgo®** (hydromorphone hydrochloride extended release tablets)	❒ **Xartemis™ XR** (oxycodone HC1/acetaminophen extended release)
❑ **MorphaBond™ ER** (morphine sulfate extended release) tablets	

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

Drug Name/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 malignant (cancer) pain **OR**
- ❑ Patient has non-malignant pain with a diagnosis of: _____ **AND**
- ❑ Patient has received the following ***three (3)*** opioids in attempt to treat this intractable pain:

Date	Drug	Dose & Frequency

AND

Patient has received ***three (3)*** additional pain therapies (anti-seizures meds, antidepressants, TENS unit, etc.)

Date	Therapy	Dose & Frequency

- ❑ **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:** 11/17/2016; **REVISED/UPDATED:** ~~12/6/2016; 12/19/2016; 5/20/2017; 8/23/2017;~~ **9/27/2017**;