OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST FORM*

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)*: *Short-Acting Narcotics* ***(COMMERCIAL ONLY)***

❒ **Nucynta**® (tapentadol)	❑ **Oxaydo**® (oxycodone HCI, USP)
❒ **Opana**® (oxymorphone)	❒ **Trezix**™ (dihydrocodeine/acetaminophen/caffeine)

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*:** _____

Authorizations are for no more than 60 days of therapy.

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

- Patient has received the following ***three (3)*** short acting opioids in attempt to treat this acute pain condition:

Date	Drug	Dose & Frequency

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