

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: **Actiq®** (oral transmucosal fentanyl citrate)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

{Opioid tolerance is defined as taking at least 60 mg morphine/day, 50 mcg transdermal fentanyl/hour or an equianalgesic dose of another opioid for a week or longer.}

CLINICAL CRITERIA: ALL boxes must be checked to qualify or authorization process will be delayed.

- Member has breakthrough cancer pain and is opioid tolerant
- AND**
- Member or caregiver was instructed on disposal of completely or partially used Actiq® units.
- 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: 11/21/02
REVISED/UPDATED: 6/6/11; 8/11/2011; 4/8/2014; 11/6/2014; 5/21/2015; 6/30/2015; 12/24/2015; 12/15/2016; 8/9/2017.