

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: Cambia™ (diclofenac potassium powder)

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: _____

CLINICAL CRITERIA: The following **MUST** be met to qualify or authorization process will be delayed.

Patient has tried and failed therapy with **ONE (1)** of the following

<input type="checkbox"/> sumatriptan	<input type="checkbox"/> rizatriptan
<input type="checkbox"/> naratriptan	<input type="checkbox"/> zolmitriptan

****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: 10/21/2010

UPDATED: 5/19/2011; 6/14/2011; 8/12/2011; 11/25/2011; 11/22/2012; 3/14/2013; 8/22/14; 9/23/2014; 10/30/2014; 5/21/2015; 12/27/2015; 12/15/2016; 8/9/2017