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: **Conzip™** (tramadol) ***(COMMERCIAL ONLY)***

***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:** ALL information below MUST be met. To qualify, boxes MUST be checked or authorization process will be delayed.*

- ❑ Patient is ≥ 18 years of age
- ❑ Patient has tried and failed tramadol extended-release.
- ❑ **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**: 11/22/2012
REVISED/UPDATED: ~~3/29/13; 10/30/2014; 5/21/2015; 6/30/2015; 12/27/2015; 12/20/2016;~~ **8/10/2017**