

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 below):

Fentanyl Orals

<input type="checkbox"/> Fentora ® (fentanyl buccal tablets),	<input type="checkbox"/> Lazanda ® (fentanyl nasal spray)
<input type="checkbox"/> Subsys ™ (fentanyl sublingual spray)	

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: _____

{RECOMMENDED DOSING: Therapy should always be initiated with the lowest strength available. This is 100 mcg for Fentora®, Lazanda® and Subsys™.

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

- Patient is ≥ 18 years of age.
- Member has breakthrough cancer pain and is opioid tolerant.

AND

- Member has failed a trial of oral transmucosal fentanyl citrate (requires a PA).

AND

- Member has failed a trial of Abstral® (fentanyl sublingual tablets requiring a PA).
- 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 #: _____