

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: **Flector®** (diclofenac epolamine 1.3%)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

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

- Patient has tried and failed topical capsaicin.

AND

- Patient has tried and failed **four NSAIDs** from the Optima Preferred Drug List. (**Check all tried.**)

<input type="checkbox"/> diclofenac sodium	<input type="checkbox"/> diflunisal	<input type="checkbox"/> etodolac
<input type="checkbox"/> fenoprofen	<input type="checkbox"/> flurbiprofen	<input type="checkbox"/> ibuprofen
<input type="checkbox"/> indomethacin, SR	<input type="checkbox"/> ketoprofen, SR	<input type="checkbox"/> ketorolac
<input type="checkbox"/> meclofenamate	<input type="checkbox"/> nabumetone	<input type="checkbox"/> naproxen
<input type="checkbox"/> naproxen sodium	<input type="checkbox"/> oxaprozin	<input type="checkbox"/> piroxicam
<input type="checkbox"/> sulindac	<input type="checkbox"/> tolmetin	<input type="checkbox"/> meloxicam

OR

- Patient has a contraindication to NSAIDs, specifically (list below)

****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: 2/19/2015

REVISED/UPDATED: 5/27/2015; 12/27/2015; 12/16/2016; 8/13/2017; 9/28/2017.