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 Category: ***MIGRAINE ABORTIVE DRUGS***

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***: _____

Oral Drug Requested *(select one)*:	
❑ **Axert**® (almotriptan)	❑ **Frova**® (frovatriptan)
❑ **Relpax**® (eletriptan)	❑ **Treximet**® (sumatriptan/ naproxen sodium)

CLINICAL CRITERIA. Reason for Request for Oral Drug: At least ONE of the following criteria MUST be met or authorization process will be delayed.

❑ Patient has tried and failed therapy with ***at least two (2)*** of the following triptans:

❑ sumatriptan	❑ rizatriptan
❑ naratriptan	❑ zolmitriptan

❑ Patient enrolled with Optima Health within the past three months and was stable on requested medication prior to enrollment ***(subject to verification by Optima Health)***

Injectable Drug Requested *(select one)*:	
❑ **Sumavel Dose Pro**® (sumatriptan)	❑ **Zembrace**™ (sumatriptan)

CLINICAL CRITERIA. Reason for Request for injectable drug. At least ONE of the following criteria MUST be met or authorization process will be delayed.

❑ Patient has tried and failed therapy with sumatriptan injections.

❑ Patient enrolled with Optima Health within the past three months and was stable on requested medication prior to enrollment ***(subject to verification by Optima Health)***.

***Nasal Spray Requested*:** ❑ **Zomig**® (zolmitriptan)

CLINICAL CRITERIA. Reason for Request for Zomig® Nasal Spray. At least ONE of the following criteria MUST be met or authorization process will be delayed.

❑ Patient has tried and failed therapy with sumatriptan nasal spray.

❑ Patient enrolled with Optima Health within the past three months and was stable on requested medication prior to enrollment ***(subject to verification by Optima Health)*.**

(signature on next page)

*****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:** 11/19/2009
UPDATED/REVISED: ~~11/18/2010;~~ ~~5/11/2011;~~ ~~6/29/2011;~~ ~~8/18/2011;~~ ~~9/15/2011;~~ ~~10/31/2011,~~ ~~11/7/2012,,~~ ~~3/14/2013, 7/29/2013;~~ ~~11/21/2013;1/162014;~~ ~~2/6/2014;~~ ~~4/4/2014 ;~~ ~~4/17/2014;~~ ~~5/15/2014;~~ ~~5/28/2014;~~ ~~8/18/2014;~~ ~~9/5/2014;~~ ~~9/26/2014;~~ ~~9/29/2014;~~ ~~10/30/2014;~~ ~~5/21/2015;~~ ~~12/27/2015;~~ ~~4/29/2016;~~ ~~6/16/2016;~~ ~~8/22/2016;;~~ ~~10/3/2016;~~ ~~12/19/2016;~~ ~~8/14/2017;~~ ~~9/5/2017;~~ **6/3/2018**;