OPTUMRx®

Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Optima Health

Fentora®, Lazanda®, Subsys® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the requested drug below:
❑ Fentora ❑ Lazanda ❑ Subsys

Select the diagnosis below:
❑ Breakthrough cancer pain
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:
Is the patient opioid tolerant? ❑ **Yes** ❑ **No**
Has the patient failed a trial of oral transmucosal fentanyl citrate*? ❑ **Yes** ❑ **No**
Has the patient failed a trial of Abstral*? ❑ **Yes** ❑ **No**
** Please note: This product requires prior authorization*
Has the provider checked information on this patient in the state's Prescription Monitoring Program (PMP) database within the last 90 days? ❑ **Yes** ❑ **No**
If **Yes** to the above, document date PMP database was checked: _____

Quantity limit requests:
What is the quantity requested per DAY? _____
Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____
_____
Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**
If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).
*** Please note: Chart documentation of the above is required to be submitted along with this fax*

_____
_____

****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.
Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.