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; **(Pharmacy) 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Stadol® Nasal Spray (butorphanol nasal)

DRUG INFORMATION: Complete information below or authorization 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. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

- ❑ Patient has a diagnosis of headaches
- ❑ Patient has tried **at least three** other rescue and/or abortive medications
- ❑ **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: 12/8/2008
REVISED/UPDATED: ~~6/8/2011; 9/8/2011; 11/5/2014; 5/22/2015; 6/25/2015; 12/29/2015; 12/20/2016; 8/17/2017;~~ **(Reformatted) 6/19/2019**