OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Butalbital Combination Products
Prior Authorization Request Form (Page 1 of 2)

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 diagnosis below:

❑ Muscle contraction headache
❑ Tension-type headache
❑ Other diagnosis: _____ ICD-10 Code(s): _____

The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.

Risk acknowledgment:

Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? ❑ **Yes** ❑ **No**

Does the provider wish to proceed with the originally prescribed medication? ❑ **Yes** ❑ **No**

Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Ascomp-codeine
❑ Butalbital-acetaminophen (APAP) 50mg-300mg tablet
❑ Butalbital-APAP 50mg-325mg tablet
❑ Butalbital-APAP-caffeine 50mg-300mg-40mg capsule
❑ Butalbital-APAP-caffeine 50mg-325mg-40mg capsule
❑ Butalbital-APAP-caffeine tablet
❑ Butalbital-APAP-caffeine-codeine
❑ Butalbital-aspirin-caffeine
❑ Butalbital-aspirin-caffeine-codeine
❑ Cambia
❑ Diclofenac potassium
❑ Diclofenac sodium delayed-release (DR)
❑ Diclofenac sodium extended-release (ER)
❑ EC-Naprosyn
❑ Fenoprofen
❑ Ibu
❑ Ibuprofen
❑ Ketoprofen
❑ Ketoprofen ER
❑ Nalfon
❑ Naprelan
❑ Naproxen
❑ Naproxen DR
❑ Naproxen sodium
❑ Naproxen sodium ER
❑ Phrenilin Forte
❑ Profeno
❑ Tencon
❑ Vanatol LQ
❑ Zebutal

Butalbital Combination Products
Prior Authorization Request Form (Page 2 of 2)

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Quantity limit requests:

Note: *If the patient exceeds the maximum FDA approved dosing of 4 grams of acetaminophen per day because he/she needs extra medication due to reasons such as going on a vacation, replacement for a stolen medication, provider changed to another medication that has acetaminophen, or provider changed the dosing of the medication that resulted in acetaminophen exceeding 4 grams per day,* ***please have the patient's pharmacy contact the OptumRx Pharmacy Helpdesk at (800) 788-7871 at the time they are filling the prescription for a one-time override.***

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

*Please note: The FDA max dosage for butalbital is **300mg/day** and the FDA max dosage for acetaminophen is **4000mg/day**.

Quantity limit requests (continued):

For codeine-containing products, also answer the following:

Does the patient's diagnosis include malignant (cancer) pain? ❑ **Yes** ❑ **No**

Is the medication being used to treat postoperative pain? ❑ **Yes** ❑ **No**

If yes, answer the following**:**

Is the medication being prescribed for pain related to a dental procedure? ❑ **Yes** ❑ **No**

Is the requested dose being prescribed the same dose that the patient was stable on prior to discharge? ❑ **Yes** ❑ **No**

Was the medication prescribed by a pain specialist or by pain management consultation? ❑ **Yes** ❑ **No**

Select all of the following that have been maintained and documented in chart notes*:

- ❑ A description of the nature and intensity of the pain
- ❑ An appropriate patient medical history and physical examination
- ❑ An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
- ❑ Appropriate dose escalation
- ❑ Ongoing, periodic review of the course of opioid therapy
- ❑ Verification that the risks and benefits of the use of the requested drug have been discussed with the patient, significant other(s), and/or guardian

Chart documentation:

Will chart documentation be submitted to *OptumRx*® with this form, confirming the above information? ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted for quantity limit requests for this drug.*

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.