

OPTIMA FAMILY CARE MEDALLION 4.0

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 forms will delay the authorization process.

Drug Requested: Alunbrig® (brigatinib) tablets

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength/Quantity per Day: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: To receive a **THREE (3) month approval** for this drug, **ALL** appropriate boxes below **must** be checked to ensure the authorization process will **NOT** be delayed.

Does member meet the following criteria?

- Is Prescriber an oncologist? Yes No
- Has member been diagnosed with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib? Yes No
- Is member 18 years of age or older? Yes No
- If female, is member pregnant or breast feeding? Yes No
- If approved, initial prescription fill for 7 days' supply to ensure patient tolerance. Yes No
Additional refills may be up to 34-days' supply.
- Accelerated approval – monitor for clinical benefit on tumor response. Yes No
- If approved, assess fasting blood glucose prior to therapy initiation and regularly during treatment. Monitor respiratory system function, blood pressure and heart rate after 2 weeks and then monthly thereafter. Monitor CPK and pancreatic enzymes regularly. Yes No
- Review drug profile for CYP3A inhibitors, CYP3A inducers, and hormonal contraceptives. Yes No

****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 #: _____