

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 form will delay authorization process.

Drug Requested: Calquence® (acalabrutinib) (*Medicaid*)

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

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Recommended dosage: 100 mg every 12 hours until disease progression or unacceptable toxicity

Quantity Limit: 68 tablets/34 days

Authorization approval: 1 year

CLINICAL CRITERIA: The following questions **MUST** be checked to ensure authorization process will **NOT** be delayed.

1. Does member have a diagnosis of advance mantle cell lymphoma? Yes No
2. Is prescriber an oncologist? Yes No
3. Is member ≥ 18 years of age? Yes No
4. Will member be using acalabrutinib as a single agent? Yes No
5. Has member received at least 1 prior therapy for mantle cell lymphoma? Yes No
6. Has member received any prior treatment with a Bruton's tyrosine kinase (BTK) inhibitor (acalabrutinib or ibrutinib)? Yes No
7. If female, is member pregnant or breast feeding? 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 #: _____

REVISED/UPDATED: 7/1/2018