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: ***(check applicable box below)***

❑ **Erivedge**® (vismodegib)	❑ **Odomzo**® (sonidegib)

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:*** _____________

Maximum Quantity Allowed: 30 capsules for 30 days

CLINICAL CRITERIA: To receive a ONE (1) year approval for either Erivedge or Odomzo, ALL applicable boxes must be checked to qualify to ensure the authorization process will NOT be delayed.

Does member meet the following criteria?

❑ For **Erivedge**®:

- Member has been diagnosed with metastatic basal cell carcinoma? ❑ Yes ❑ No

  OR

- Member has a diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or is not a candidate for surgery and radiation? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- If female, patient is not pregnant. ❑ Yes ❑ No

❑ **Odomzo**®

- Member has a diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or radiation therapy, or those who are NOT candidates for surgery or radiation therapy? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- If female, patient is not pregnant. ❑ Yes ❑ No
- Baseline serum creatine kinase and creatinine levels have been obtained? ❑ 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