

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: Erleada™ (apalutamide) (*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: 240 mg (four 60 mg tablets) once daily

Quantity Limit: 120 tablets/30 days

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

Initial Approval Criteria: 6 months. All information below **MUST** be completed to qualify.

1. Does member have a diagnosis of NON-metastatic castration-resistant prostate cancer (nmCRPC)? **AND**
 Yes No
2. Is prescriber an oncologist? **AND** Yes No
3. Is member ≥ 18 years of age? **AND** Yes No
4. Member will receive a gonadotropin-releasing hormone (GnRH)-analog or the member has had a bilateral orchiectomy. Yes No

Renewal Approval Criteria: One (1) Year. All information **MUST** be completed to qualify.

1. Member continues to meet the above criteria? Yes No
AND
2. There is tumor response with stabilization of disease or decrease in size of tumor or tumor spread.
 Yes No
AND
3. Absence of unacceptable toxicity from the drug? *Examples of unacceptable toxicity include seizures, excessive falls and/or fractures, and any other Grade 3 or above side effects that are intolerable to the member?*
 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 #: _____