

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: Farydak® (panobinostat)

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 **SIX (6) month approval** for this drug, **ALL** appropriate boxes below **must** be checked to qualify to ensure the authorization process will **NOT** be delayed.

• Prescriber is an: oncologist OR hematologist Yes No

• Does member meet the following criteria?

• Is member 18 years of age or older? Yes No

• Diagnosis of relapsed multiple myeloma Yes No

• Member has received at least two (2) prior regimens with bortezomib (Velcade®) and an immunomodulatory derivative (thalidomide (Thalomid®), lenalidomide (Revlimid®), or pomalidomide (Pomalyst®)? Yes No

• State regimen and dates of therapy:

Drug or Treatment Protocol Name: _____ Date received: _____

Drug or Treatment Protocol Name: _____ Date received: _____

Drug or Treatment Protocol Name: _____ Date received: _____

• Member is concurrently receiving treatment with bortezomib (Velcade®) and dexamethasone? Yes No

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication and attach to this request.

****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 #: _____