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: Gilotrif™ (afatinib)

***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 ensure the authorization process will *NOT* be delayed.**

- Is medication being prescribed by an oncologist or a hematologist? ❑ Yes ❑ No
- Is patient 18 years old or older? ❑ Yes ❑ No
- Does member have the following diagnosis?
- Metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations? ❑ Yes ❑ No
- Has member tested positive for EGFR exon 19 deletions or exon 21 (L858R) substitution mutations with an FDA approved test? ***If YES, please provide testing results (Information on FDA-approved tests for the detection of EGFR mutations for NSCLC may be found at http://www.fda.gov/Companiondiagnostics)*** ❑ 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 #: _____

REVISED/UPDATED: 7/1/2018