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: **Iclusig®** (ponatinib)

***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:*** _____

Gender: ❑ Female ❑ Male **Weight in Kilograms**: _____

***CLINICAL CRITERIA:* To receive a *SIX (6) month approval* for this drug, complete the following questions to ensure the authorization process will *NOT* be delayed.**

1. Diagnosis of ***ANY*** of the following:
   a. Treatment of adult patients with T315l-positive chronic myeloid leukemia (chronic phase, accelerated phase, or blast phase: ❑ Yes ❑ No
   b. Treatment of adult patients with T315l-positive Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL): ❑ Yes ❑ No
   c. Treatment of adult patients with chronic phase, accelerated phase, or blast phase chronic myeloid leukemia or Ph+ ALL for whom no other tyrosine kinase inhibitor (TKI) therapy is indicated: ❑ Yes ❑ No
2. Is the medication being prescribed by an oncologist? ❑ Yes ❑ No
3. Is the patient 18 years of age or older? ❑ Yes ❑ No
4. Has the patient been tested for high uric acid levels? ❑ Yes ❑ No
5. Patient will have heart and liver function checked prior to implementing therapy and during therapy? ❑ Yes ❑ No
6. Patient will be monitored for evidence of thromboembolism and vascular occlusion? ❑ Yes ❑ No

***MEDICAL NECESSITY:* Provide clinical evidence that supports the use of the requested medication:**

_____

_____

Medication being provided by a Specialty Pharmacy - PropriumRx

*****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