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: Imbruvica® (ibrutinib) capsules

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 the medication being prescribed by an oncologist or a hematologist? ❑ Yes ❑ No
- Is member 18 years old or older? ❑ Yes ❑ No
- Does member have one of the following diagnoses?
  - Mantle cell lymphoma (MCL) and has received at least **ONE** prior therapy? ❑ Yes ❑ No

    OR
  - Chronic lymphocytic leukemia (CLL) patients who have received at least **ONE** prior therapy? ❑ Yes ❑ No

    OR
  - Waldenstrom's macroglobulinemia (WM) and has received at least **ONE** prior therapy? ❑ Yes ❑ No
- Has member received one prior treatment for the associated disease state? ❑ Yes ❑ No

  (If YES, please notate below prior treatment used and the citation or reference for use.)

Prior therapy for MCL, CLL, or WM

Drug or Treatment Protocol Name: ______________________ *Date received:* ______________

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Drug or Treatment Protocol Name: ______________________ *Date received:* ______________

- Compliant with National Comprehensive Cancer Network (NCCN) guidelines? ❑ Yes ❑ No

  (If NO, please cite reference for use: ____

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

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*****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