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: Kisqali®-Femara® (ribociclib-letrozole)

***DRUG INFORMATION:* Complete all information below or authorization will be delayed.**

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ ***ICD Code, if applicable*:** _____

***CLINICAL CRITERIA:* To receive a SIX (6) month approval for this drug, all boxes below must be checked to qualify to ensure authorization process will NOT be delayed. Chart notes/lab results MUST BE INCLUDED with this request.**

- ***Does member meet the following criteria?***
  1. Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer who is receiving an aromatase inhibitor: ❑ Yes ❑ No

     Please identify inhibitor below:

     A. _____

     B. _____
  2. Is prescriber an oncologist? ❑ Yes ❑ No
  3. Is member ≥ 18 years of age? ❑ Yes ❑ No
  4. If female, is member pregnant or breast feeding? ❑ Yes ❑ No
  5. **If approved, monitor ECG and electrolytes prior to initiation of therapy, 14 days after first cycle, then at the beginning of each cycle for 6 cycles. Perform liver function tests before initiating therapy, every 2 weeks for the first 2 cycles and at the beginning of the next 4 cycles.**
  6. **Review medication profile. Avoid CYP3A4 inhibitors, CYP3A inducers and drugs known to prolong QT interval.**

***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: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~7/1/2018;~~ **7/18/2018**;