

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 (check applicable box below):

<input type="checkbox"/> Mekinist® (trametinib)	<input type="checkbox"/> Tafinlar® (dabrafenib)
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DRUG INFORMATION: Complete below. If incomplete, authorization process will be delayed.

Drug Name: _____

Drug Form/Strength/Quantity per Day: _____

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

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

CLINICAL CRITERIA: To receive a **THREE (3)-month approval** for the drugs listed below, **ALL** appropriate lines **MUST** be checked to qualify. Authorization process will be delayed if **not** completed.

For Mekinist®: Medical notes/lab values/test results **MUST** be included with this request or authorization process will be delayed.

- Is drug being prescribed by an oncologist? Yes No
 - Is patient 18 years old or older? Yes No
 - Has member been diagnosed with unresectable or metastatic melanoma with BRAF V600E or V600K mutation? Yes No
 - Has mutation been detected/confirmed by a FDA-approved test? Yes No
- (Documentation required; include a copy of the test results with this fax.)*

For Tafinlar®: Medical notes/lab values/test results **MUST** be included with this request or authorization process will be delayed.

- Is drug being prescribed by an oncologist? Yes No
 - Is member 8 years old or older? Yes No
 - Does member have a diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation? Yes No
 - Has member been diagnosed with a wild-type BRAF melanoma? Yes No
 - Has mutation been detected/confirmed by a FDA-approved test? Yes No
- (Documentation required; include a copy of the test results with this fax.)*
- Is patient pregnant? Yes No

****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 #: _____