

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: Ninlaro® (ixazomib)

DRUG INFORMATION: Complete information below. If incomplete, 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 qualify or authorization process will be delayed.

Does member meet the following criteria?

- Is prescriber an oncologist? Yes No
- Is member 18 years of age or older? Yes No
- Has member received at one (1) prior treatment for diagnosis? Yes No

If YES, provide name of treatment regimen and dates of therapy below:

Yes No

Treatment _____ Date received: _____

Treatment _____ Date received: _____

Treatment _____ Date received: _____

- Will member be receiving both lenalidomide (Revlimid®) and dexamethasone? Yes No
- Has prior authorization request for lenalidomide (Revlimid®) been completed and approved? Yes No
- Will strong CYP3A inducers (i.e., rifampin, phenytoin, carbamazepine, St John's Wort) be administered concurrently? Yes No
- Is member receiving concurrent therapy with another proteasome inhibitor? Yes No

Examples include: bortezomib (Velcade®), cafilzomib ((Kyprolis®) (list drugs below)

****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 #: _____