

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: Valchlor® (mechlorethamine)

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 ONE (1) year approval for this drug, ALL appropriate boxes below must be checked to qualify or authorization process will be delayed.

Prescriber is: Dermatologist Oncologist Yes No

Does member meet the following criteria?

- Is member 18 years of age or older? Yes No
- Stage 1A and 1B mycosis fungoides-type cutaneous T-cell lymphoma? Yes No
- Has member tried at least one of the following skin-directed therapies? Yes No
 - Topical corticosteroids? Yes No
 - Topical retinoids [bexarotene (Targetin®), tazatotene (Tazorac®)]? Yes No
 - Local radiation? Yes No
 - Phototherapy? Yes No
 - Topical imiquimod (Aldara®)? Yes No

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

****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 #: _____