

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: Venclexta™ (venetoclax)

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

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: All boxes that apply **must** be checked to qualify. Authorization process will be delayed if **not** checked.

Diagnosis of chronic lymphocytic leukemia (CLL)

AND

Confirmation of the presence of 17p deletion as detected by an FDA approved test

AND

Failure or clinically significant adverse effects to at least one previous therapy:

- Imbruvica® (ibrutinib)
- High dose methylprednisolone + rituximab (Rituxan®)
- Fludarabine, cyclophosphamide, rituximab (FCR)
- Fludarabine + rituximab (FR)
- Gazyva® (obinutuzumab) + chlorambucil
- Campath® (alemtuzumab) + rituximab
- Zydelig® (idelalisib) +/- rituximab

Medication being provided by a Specialty Pharmacy - Proprium Rx

****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 #: _____ Fax #: _____

DEA OR NPI #: _____