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: **Zelboraf™** (vemurafenib)

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:*** ______________

RECOMMENDED DOSAGE: ***960mg orally twice daily.***

CLINICAL CRITERIA: To receive a THREE (3) month approval, boxes below must be checked. Medical notes/lab tests, etc. MUST be attached with this request or authorization will be delayed.

- ❑ Prescriber is an Oncologist? ❑ Yes ❑ No
- ❑ Does member have a diagnosis of unresectable or metastatic melanoma with the serine-threonine protein kinase BRAF V600E mutation? ❑ Yes ❑ No
- ❑ Was an FDA-approved test done to detect the presence of the BRAF V600E mutation? ❑ Yes ❑ No
  (Documentation required; include a copy of the test results with this request form)
- ❑ Has baseline monitoring been completed, which includes electrocardiogram, electrolytes, liver enzymes, and bilirubin? ***(Provide copy of labs)*** ❑ Yes ❑ No
- ❑ Has a baseline dermatologic evaluation been completed? ❑ Yes ❑ No

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: ____________________

Prescriber Name: ____

Prescriber Signature: ______________________________ Date: ____________________

Office Contact Name: ____

Phone Number: ______________________________ Fax Number: ____________________

DEA OR NPI #: ____

***REVISED/UPDATED: 7/1/2018**