

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: Zydelig® (idelalisib)

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.

- Is medication being prescribed by: oncologist OR hematologist Yes No
- Is member 18 years of age or older? Yes No
- Does member have one (1) of the following diagnoses? Yes No
 - Relapsed chronic lymphocytic leukemia (CLL) and must be used in combination with rituximab? Yes No
- OR
- Relapsed follicular B-cell non-Hodgkin lymphoma (FL) and has received at least two prior therapies? Yes No
- OR
- Relapsed small lymphocytic lymphoma (SLL) and has received at least two prior therapies Yes No

Prior Therapies for FL

Drug or Treatment Protocol Name: _____ Date received: _____

Drug or Treatment Protocol Name: _____ Date received: _____

Prior Therapies for SLL

Drug or Treatment Protocol Name: _____ Date received: _____

Drug or Treatment Protocol Name: _____ Date received: _____

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 #: _____