

# 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:**     **Zykadia™** (ceritinib)

**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:** Boxes **MUST** be checked to qualify or authorization process will be delayed.

- Patient has a diagnosis of metastatic non-small cell lung cancer
- Documented copy of ALK-positive mutation, as detected by an FDA-approved test (i.e. Vysis ALK Break-Apart Fish Probe Kit)

**AND**

- Trial and failure of:
  - crizotinib (Xalkori®)

**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