OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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: Ibrance® (palbociclib)

DRUG INFORMATION: Complete **all** information below or authorization will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: All boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed. Chart notes/lab results **MUST BE INCLUDED** with this request.

- **Does patient meet the following criteria?**
  1. Diagnosis of advanced breast cancer this is estrogen receptor positive? ❑ Yes ❑ No
  2. Is patient ≥ 18 years of age? ❑ Yes ❑ No
  3. Is medication being prescribed by an oncologist? ❑ Yes ❑ No
  4. Human epidermal growth factor receptor 2 (HER2)-negative? ❑ Yes ❑ No

  FDA Approved combination therapy requirements. Note Ibrance® is NOT indicated for monotherapy.

  - Ibrance with letrozole:
    - Postmenopausal? ❑ Yes ❑ No
  - Ibrance with fulvestrant:
    - Failed prior endocrine therapy ❑ Yes ❑ No
    - Patient may be pre-or postmenopausal? ❑ Yes ❑ No

Medical Necessity: Provide clinical evidence that support the use of the requested medication.

_____

_____

_____

Medication being provided by a Specialty Pharmacy - PropriumRx

(Continued on next page; signature MUST be included with this request.)

(Signature page MUST be included with 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: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~7/26/2017;~~ ~~6/23/2018;~~ **8/22/2018**;