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 forms will delay the authorization process**.

Drug Requested: Alecensa® (alectinib)

DRUG INFORMATION: Complete information below or 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.

Does member meet the following criteria?

- Is medication being prescribed by an oncologist? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- Diagnosis of anaplastic lymphoma kinase (ALK) – positive metastatic non-small cell lung cancer? ❑ Yes ❑ No
- Diagnosis confirmed by FDA approved genetic test? ❑ Yes ❑ No
- Has member had an intolerance or progression of disease while on crizotinib (Xalkori™)?
- ❑ Yes ❑ No
- Will member have LFTs (every two weeks for the first two months of therapy) and CPK (every two weeks for the first month of therapy)? ❑ Yes ❑ No
- Is dose equal to or greater than 300mg (2x150mg) orally twice daily? ❑ Yes ❑ No

(Package insert states this is the **minimum effective dosage**; however, clinical practice and greater use may yield exceptions, if dosage is lower, please explain rationale below)

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request. If not included, authorization process will be delayed.

_____

_____

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(Continued on next page; signature ***MUST*** be attached to this request.)

(Signature page **MUST** be attached 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 #: _____

REVISED/UPDATED: 12/23/2017; **8/15/2018**;