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 1-800-319-5003**. 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: Alunbrig® (brigatinib) tablets

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 **THREE (3) 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 Prescriber an oncologist? ❑ Yes ❑ No
- Has member been diagnosed with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- If female, is member pregnant or breast feeding? ❑ Yes ❑ No
- If approved, initial prescription fill for 7 days' supply to ensure patient tolerance. ❑ Yes ❑ No
  Additional refills may be up to 34-days' supply.
- Accelerated approval – monitor for clinical benefit on tumor response. ❑ Yes ❑ No
- If approved, assess fasting blood glucose prior to therapy initiation and regularly during treatment. Monitor respiratory system function, blood pressure and heart rate after 2 weeks and then monthly thereafter. Monitor CPK and pancreatic enzymes regularly. ❑ Yes ❑ No
- Review drug profile for CYP3A inhibitors, CYP3A inducers, and hormonal contraceptives. ❑ Yes ❑ No

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

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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**;