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: Calquence® (acalabrutinib)

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

Drug Form/Strength: ____

Dosing Schedule: ______________________________ **Length of Therapy**: ____________________

Diagnosis: ______________________________ ***ICD Code, if applicable***: ____________________

Recommended dosage: 100 mg every 12 hours until disease progression or unacceptable toxicity

Quantity Limit: 68 tablets/34 days

Authorization approval: 1 year

CLINICAL CRITERIA: The following questions **MUST** be checked to ensure authorization process will **NOT** be delayed.

1. Does member have a diagnosis of advance mantle cell lymphoma? ❑ Yes ❑ No
2. Is prescriber an oncologist? ❑ Yes ❑ No
3. Is member ≥ 18 years of age? ❑ Yes ❑ No
4. Will member be using acalabrutinib as a single agent? ❑ Yes ❑ No
5. Has member received at least 1 prior therapy for mantle cell lymphoma? ❑ Yes ❑ No
6. Has member received any prior treatment with a Bruton's tyrosine kinase (BTK) inhibitor (acalabrutinib or ibrutinib)? ❑ Yes ❑ No
7. If female, is member pregnant or breast feeding? ❑ Yes ❑ No

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;~~ **8/17/2018**