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: Cotellic™ (cobimetinib)

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 the medication being prescribed by an oncologist? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation? ❑ Yes ❑ No
- BRAF V600E or V600K mutation detected by an FDA-approved test prior to starting treatment? ❑ Yes ❑ No
- Dermatologic evaluation done prior to initiating therapy? ❑ Yes ❑ No
- Left ventricular ejection fraction evaluation (LVEF) at baseline (safety when LVEF ≤ 50% has not been evaluated) ❑ Yes ❑ No
- Baseline serum creatinine and creatine phosphokinase (CPK) performed? ❑ Yes ❑ No
- Is vemurafenib (Zelboraf®) being prescribed concurrently? (Please ensure prior authorization is completed at the same time) ❑ Yes ❑ No
- Is member currently taking moderate or strong CYP3A4 inhibitors or inducers**?** (Dose modifications may be needed) ❑ Yes ❑ No
- Has member had disease progression while previously on the combination of BRAF inhibitor Tafinlar (dabrafenib) and the MEK inhibitor Mekinist (trametinib)? ❑ Yes ❑ No

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request.

_____

_____

_____

(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: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~12/23/2017;~~ **8/17/2018**