

**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: *(check applicable box below)*

Erivedge® (vismodegib)

Odomzo® (sonidegib)

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:** _____

Maximum Quantity Allowed: 30 capsules for 30 days

CLINICAL CRITERIA: To receive a **ONE (1) year approval** for either Erivedge or Odomzo, **ALL** appropriate boxes below **must** be checked to qualify or authorization process will be delayed.

Does member meet the following criteria?

For **Erivedge®**:

- Member has been diagnosed with metastatic basal cell carcinoma? Yes No

OR

- Member has a diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or is not a candidate for surgery and radiation? Yes No
- Is member 18 years of age or older? Yes No
- If female, patient is not pregnant. Yes No

Odomzo®

- Member has a diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or radiation therapy, or those who are NOT candidates for surgery or radiation therapy? Yes No
- Is member 18 years of age or older? Yes No
- If female, patient is not pregnant. Yes No
- Baseline serum creatine kinase and creatinine levels have been obtained? Yes No

(continued 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~~; 8/18/2018;