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: Erleada™ (apalutamide)

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: 240 mg (four 60 mg tablets) once daily

Quantity Limit: 120 tablets/30 days

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

Initial Approval Criteria: 6 months.
All information below MUST be completed to qualify.

1. Does member have a diagnosis of NON-metastatic castration-resistant prostate cancer (nmCRPC)? **AND** ❑ Yes ❑ No
2. Is prescriber an oncologist? **AND** ❑ Yes ❑ No
3. Is member ≥ 18 years of age? **AND** ❑ Yes ❑ No
4. Member will receive a gonadotropin-releasing hormone (GnRH)-analog or the member has had a bilateral orchiectomy. ❑ Yes ❑ No

Renewal Approval Criteria: One (1) Year.
All information MUST be completed to qualify.

1. Member continues to meet the above criteria? ❑ Yes ❑ No

AND

2. There is tumor response with stabilization of disease or decrease in size of tumor or tumor spread. ❑ Yes ❑ No

AND

3. Absence of unacceptable toxicity from the drug? Examples of unacceptable toxicity include seizures, excessive falls and/or fractures, and any other Grade 3 or above side effects that are intolerable to the member? ❑ Yes ❑ No

(continued on next page; signature page 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: ~~7/1/2018;~~ **8/20/2018**;