OPTIMA HEALTH COMMUNITY CARE
AND
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: Farydak® (panobinstat)

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.

- **Prescriber is an:** ❑ **Oncologist** **OR** ❑ **Hematologist** ❑ Yes ❑ No
- **Does member meet the following criteria?**
  - Is member 18 years of age or older? ❑ Yes ❑ No
  - Diagnosis of relapsed multiple myeloma ❑ Yes ❑ No
  - Member has received at least two (2) prior regimens with bortezomib (Velcade®) and an immunomodulatory derivative (thalidomide (Thalomid®), lenalidomide (Revlimid®), or pomalidomide (Pomalyst®)? ❑ Yes ❑ No
  - State regimen and dates of therapy:

Drug or Treatment Protocol Name: _____ **Date received:** _____

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- Member is concurrently receiving treatment with bortezomib (Velcade®) and dexamethasone? ❑ Yes ❑ No

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request or authorization process will be delayed.

_____

_____

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

(Signature page MUST be attached to 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;~~ **8/20/2018**;