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. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Drug Requested: **Gilotrif**™ (afatinib)

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

Drug Form/Strength: ____

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

Diagnosis: ___________________________________ **ICD Code, if applicable:** _______________

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

Approval Authorization – Six (6) months

1) Metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations? ❑ Yes ❑ No

OR

2) Metastatic squamous MSCLC progressing after platinum-based chemotherapy? ❑ Yes ❑ No

   Which platinum-based chemo? ____

3) Has patient tested positive for EGFR exon 19 deletions or exon 21 (L858R) substitution mutations with an FDA approved test? ❑ Yes ❑ No

   If **YES**, please provide testing results **(Information on FDA-approved tests for the detection of EGFR mutations for NSCLC may be found at http://www.fda.gov/Companiondiagnostics).**

4) Is medication being prescribed by an oncologist or a hematologist? ❑ Yes ❑ No

5) Is patient 18 years of age or older? ❑ Yes ❑ No

6) If female, is patient pregnant or breastfeeding? ❑ Yes ❑ No

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

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(Continued on next page; signature page MUST be attached to request form)

(Signature page MUST be included with 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;~~ **(Reformatted) 4/11/2019**