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.**

(Form to be completed ONLY if the patient is self-administering.)

Drug Requested ***(select drug below):***		
❑ **Granix®** (TBO-filgrastim)	❑ **Leukine®** (sargramostim)	❑ **Neupogen®** (filgrastim)
❑ **Neulasta®** (PEG-filgrastim)	❑ **Zarxio®** (filgrastim)	

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

Drug Name/Form: _____ **Strength/Quantity:** _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Chemotherapy Regimen: _____

****Documentation of CBC with differential test results *must* be submitted with this request, unless use is for prophylaxis. ****

CLINICAL CRITERIA: **ONE (1)** of the following reasons below **MUST** be checked to qualify. Incomplete information will delay authorization process**.**

- ❑ Myelosuppressive chemotherapy in patients with nonmyeloid malignancies
- ❑ Bone Marrow Transplant
- ❑ Severe Chronic Neutropenia (ANC<1000 cells/mm^3)
- ❑ Peripheral blood progenitor cell (PBPC) collection and therapy
- ❑ Acute myeloid leukemia (AML) receiving induction or consolidation chemotherapy
- ❑ Hepatitis C therapy related Neutropenia
- ❑ HIV/therapy related Neutropenia

Medication being provided by (check applicable box below):

- ❑ **Physician's office**

  OR

- ❑ **Specialty Pharmacy - Sentara Norfolk General CM Pharmacy**

(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**: ~~8/26/2017;~~ **8/19/2018**;