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: Idhifa® (enasidenib) tablets

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:** ______________

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.

Authorization Approval Length – SIX (6) months

Does patient meet the following criteria?

1. Does patient have relapsed or refractory acute leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test? ❑ Yes ❑ No

   Information on FDA-approved tests for the detection of IDH2 mutations in AML is available at: http://www/fda.gov/

2. Is the prescriber an oncologist? ❑ Yes ❑ No
3. Is patient 18 or older? ❑ Yes ❑ No
4. If female, is patient pregnant or breast feeding? ❑ Yes ❑ No

   INFORMATIONAL: Assess blood counts and blood chemistries for leukocytosis and tumor lysis syndrome prior to the initiation of Idhifa® and monitor at a minimum of every 2 weeks for at least the first 3 months during treatment. Manage any abnormalities promptly. Interrupt dosing or reduce dose for toxicities.

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

(Signature page MUST be included with this request.)

Medication being provided by a Specialty Pharmacy - PropriumRx

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: ____________________

Physician Name: ____

Physician Signature: ______________________________ Date: ____________________

Office Contact Name: ____

Phone Number: ______________________________ Fax Number: ____________________

DEA OR NPI #: ____

REVISED/UPDATED: 4/8/2019