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 forms will delay the authorization process.**

Drug Requested: Imbruvica® (ibrutinib) capsules

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 to ensure authorization will **NOT** be delayed.

- Is the medication being prescribed by an oncologist or a hematologist? ❑ Yes ❑ No
- Is member 18 years old or older? ❑ Yes ❑ No
- Does member have one of the following diagnoses?
  - Mantle cell lymphoma (MCL) and has received at least **ONE** prior therapy? ❑ Yes ❑ No

    OR
  - Chronic lymphocytic leukemia (CLL) patients who have received at least **ONE** prior therapy? ❑ Yes ❑ No

    OR
  - Waldenstrom's macroglobulinemia (WM) and has received at least **one** prior therapy? ❑ Yes ❑ No
- Has member received one prior treatment for the associated disease state? ❑ Yes ❑ No
  (If YES, please notate below prior treatment used and the citation or reference for use.)

Prior therapy for MCL, CLL, or WM

Drug or Treatment Protocol Name: _____ Date received: _____

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- Compliant with National Comprehensive Cancer Network (NCCN) guidelines? ❑ Yes ❑ No

  (If NO, please cite reference for use: _____

(continued on next page)

(Signature page MUST be attached to this request)

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this 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; **8/22/2018**