OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE

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 the authorization process.**

Drug Name: Iressa® (gefitinib)

DRUG INFORMATION: Please complete information below or authorization will be delayed.

Drug Form/Strength/Month: ____

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

Diagnosis: ____________________________________ **ICD Code:** ____________________

CLINICAL CRITERIA: **All** boxes **MUST** be checked to qualify. Lab results **must** be attached to this request. Incomplete data will delay the authorization process.

- ❑ Prescriber is an Oncologist
- ❑ Does member have metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) ❑ Yes ❑ No
- ❑ Laboratory test was submitted documenting exon 19 deletion or exon 21. (Therascreen EGFR RGQ PCR Kit) ❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy – Sentara Norfolk General CM Pharmacy

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: 4/6/2018; **8/22/2018**