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.**

Drug Requested: Kisqali®-Femara® (ribociclib-letrozole)

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: All boxes below **must** be checked to qualify or authorization process will be delayed. Chart notes/lab results **MUST BE INCLUDED** with this request.

- **Does member meet the following criteria?**

1. Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer who is receiving an aromatase inhibitor:

   ❑ Yes ❑ No

   Please identify inhibitor below:

   1. _____

   2. _____

2. Is prescriber an oncologist? ❑ Yes ❑ No
3. Is member ≥ 18 years of age? ❑ Yes ❑ No
4. If female, is member pregnant or breast feeding? ❑ Yes ❑ No

- If approved, monitor ECG and electrolytes prior to initiation of therapy, 14 days after first cycle, then at the beginning of each cycle for 6 cycles. Perform liver function tests before initiating therapy, every 2 weeks for the first 2 cycles and at the beginning of the next 4 cycles.
- Review medication profile. Avoid CYP3A4 inhibitors, CYP3A inducers and drugs known to prolong QT interval.

(Continued on next page; signature **MUST** be attached to 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: ~~6/23/2018;~~ **8/23/2018**;