

**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: Lenvima® (lenvatinib) 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 or authorization process will be delayed.

Does member meet the following criteria?

- **Prescriber is an oncologist?** Yes No
- **Is member 18 years of age or older?** Yes No
- **Diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer?** Yes No
- **Is member pregnant? (Lenvima is embryotoxic. Advise of risk and use of contraception.)** Yes No

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 #: _____