# 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:** **Lonsurf**® (trifluridine and tipiracil)

**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.

**Does member meet the following criteria?**

- Prescriber is an oncologist? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- Diagnosis of metastatic colorectal cancer? ❑ Yes ❑ No
- Has member been previously treated with all of the following? **(check all that apply)** ❑ Yes ❑ No
  - ❑ floropyrimidine, oxaliplatin and irinotecan-based chemotherapy
  - ❑ an anti-VEGF biological therapy
  - ❑ if the mCRC is RAS wild-type, an anti-EGFR therapy
- Has a CBS been done prior to treatment and is scheduled on Day 15 of the treatment cycle? ❑ Yes ❑ No
- Baseline serum creatinine and creatine phosphokinase (CPK) performed? ❑ Yes ❑ No

*****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;~~ **8/27/2018**