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 (check applicable box below):	
❑ **Mekinist®** (trametinib)	❑ **Tafinlar®** (dabrafenib)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Name: _____

Drug Form/Strength/Quantity per Day: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: To receive a **THREE (3)-month approval** for the drugs listed below, **ALL** appropriate lines **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

For Mekinist®: Medical notes/lab values/test results **MUST** be included with this request to ensure authorization will **NOT** be delayed**.**

- Is drug being prescribed by an oncologist? ❑ Yes ❑ No
- Is patient 18 years old or older? ❑ Yes ❑ No
- Has member been diagnosed with unresectable or metastatic melanoma with BRAF V600E or V600K mutation? ❑ Yes ❑ No
- Has mutation been detected/confirmed by a FDA-approved test? ❑ Yes ❑ No
  (Documentation required; include a copy of the test results with this fax)

For Tafinlar®: Medical notes/lab values/test results **MUST** be included with this request to ensure authorization will **NOT** be delayed**.**

- Is drug being prescribed by an oncologist? ❑ Yes ❑ No
- Is member 8 years old or older? ❑ Yes ❑ No
- Does member have a diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation? ❑ Yes ❑ No
- Has member been diagnosed with a wild-type BRAF melanoma? ❑ Yes ❑ No
- Has mutation been detected/confirmed by a FDA-approved test? ❑ Yes ❑ No
  (Documentation required; include a copy of the test results with this fax.)
- Is patient pregnant? ❑ Yes ❑ No

(Continued on next page; signature **MUST** be attached to this request.)

(Signature page MUST be attached 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;~~ **8/27/2018**;