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. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Drug Requested: Nerlynx® (neratinib)

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: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

- **Does patient meet following criteria?**

1) Is this being used for the extended adjuvant treatment of an adult patient with early stage HER2-overexpressed/amplified breast cancer, to follow adjuvant trastuzumab-based therapy? ❑ YES ❑ NO
2) Is prescriber an oncologist? ❑ YES ❑ NO
3) Is patient 18 year or older? ❑ YES ❑ NO
4) If female, is patient pregnant or breast feeding? ❑ YES ❑ NO

ADDITIONAL INFORMATION:

- If approved, monitor liver function tests monthly for the first 3 months of treatment, then every 3 months while on treatment and as clinically indicated for hepatotoxicity. Withhold Nerlynx® in patients experiencing Grade 3 liver abnormalities and permanently discontinue Nerlynx® in patients experiencing Grade 4 liver abnormalities.
- If approved, initiate loperamide with the first dose of Nerlynx® and continue during first 2 cycles (56 days) of treatment.

(Continued on next page; signature page MUST be attached to request form)

(Signature page MUST be included with 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: 4/7/2019**