# 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: Ninlaro**® (ixazomib)

**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?

- Is prescriber an oncologist? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- Has member received at **one (1)** prior treatment for diagnosis? ❑ Yes ❑ No

  **If YES, provide name of treatment regimen and dates of therapy below***:* ❑ Yes ❑ No

  **Treatment** ________________________________ **Date received***:* ____________________

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  **Treatment** ________________________________ **Date received***:* ____________________

- Will member be receiving both lenalidomide (Revlimid®) and dexamethasone? ❑ Yes ❑ No
- Has prior authorization request for lenalidomide (Revlimid®) been completed and approved? ❑ Yes ❑ No
- Will strong CYP3A inducers (i.e., rifampin, phenytoin, carbamazepine, St John's Wort) be administered concurrently? ❑ Yes ❑ No
- Is member receiving concurrent therapy with another proteasome inhibitor? ❑ Yes ❑ No

  **Examples include**: bortezomib (Velcade®), cafilzomib ((Kyprolis®) **(list drugs below)**

______________________________________________________________________________

______________________________________________________________________________

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

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*****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**