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: Rydapt® (midostaurin)

DRUG INFORMATION: Complete **all** information below or authorization process 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.

Authorization Approval Length – SIX (6) months

Does member meet the following criteria?

1. Is member newly diagnosed with acute myeloid leukemia (AML) that is FLT3 mutation-positive as detected by an FDA-approved test or aggressive mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN) or mast cell leukemia? ❑ Yes ❑ No
2. Is member currently on cytarabine and daunorubicin induction and cytarabine consolidation? ❑ Yes ❑ No
3. Is prescriber an oncologist? ❑ Yes ❑ No
4. Is member 18 years or older? ❑ Yes ❑ No
5. If female, is member pregnant or breast feeding? ❑ Yes ❑ No
6. If approved, fill initial prescription for 14 days' supply to ensure patient tolerance. **(Additional refills may be up to 34 days' supply.)**
7. Accelerated approval-monitor for clinical benefit on tumor response. ❑ Yes ❑ No
8. Monitor pulmonary function for interstitial lung disease or pneumonitis.
9. Review drug profile for CYP3A inhibitors and CYP3A inducers.

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

(Signature page MUST be included with this request.)

Medication being provided by a Specialty Pharmacy - PropriumRx

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: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 4/8/2019