

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: **Tagrisso™ (osimertinib)**

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

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: Check **all** boxes that apply. Boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed.

- Does the member have Tumor T790M EGFR mutation status (please submit tumor biopsy or plasma specimen)? Yes No

- Non-small cell lung cancer, metastatic (T790M EGFR)? Yes No

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: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____