

**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: **Tykerb™** (lapatinib)

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

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: Box **MUST** be checked to qualify to ensure authorization will NOT be delayed.

- Patient is HER2 positive and is in need of combination treatment with capecitabine (Xeloda®) for advanced or metastatic breast cancer AND patient has failed prior therapy with other cancer drugs, including an anthracycline, a taxane, and trastuzumab.

OR

- Patient is HER2 positive and a postmenopausal woman in need of combination treatment with letrozole (Femara®) for treatment of metastatic breast cancer for whom hormonal therapy is indicated.

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 #: _____

*REVISED/UPDATED: 8/27/2017 8/31/2018