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: Venclexta™ (venetoclax)

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: **All** boxes that apply **must** be checked to qualify to ensure authorization will **NOT** be delayed.

- ❑ Diagnosis of chronic lymphocytic leukemia (CLL)

  AND

- ❑ Confirmation of the presence of 17p deletion as detected by an FDA approved test

  AND

- ❑ Failure or clinically significant adverse effects to at least one previous therapy:
  - ❑ Imbruvica® (ibrutinib)
  - ❑ High dose methylprednisolone + rituximab (Rituxan®)
  - ❑ Fludarabine, cyclophosphamide, rituximab (FCR)
  - ❑ Fludarabine + rituximab (FR)
  - ❑ Gazyva® (obinutuzumab) + chlorambucil
  - ❑ Campath® (alemtuzumab) + rituximab
  - ❑ Zydelig® (idelalisib) +/- rituximab

Medication being provided by a Specialty Pharmacy - Proprium Rx

(Continued on next page; signature page MUST be included with this request.)

(Signature page MUST be attached to 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 #: _____ Fax #: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~7/26/2017;~~ **8/31/2018**