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: **Xalkori**™ (crizotinib)

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

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy:** ______________________

Diagnosis: ______________________ **ICD Code, if applicable:** ______________

RECOMMENDED DOSAGE: 200mg or 250mg orally twice daily.

CLINICAL CRITERIA: To receive a **THREE (3) month approval**, boxes below **must** be checked. Medical charts/test results, etc. **MUST** be attached with this request to ensure authorization will **NOT** be delayed.

- ❑ Prescriber is an Oncologist? ❑ Yes ❑ No
- ❑ Does member have a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC)? ❑ Yes ❑ No
- ❑ Is member anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test? **(If YES, please provide chart notes documenting that member is ALK-positive)** ❑ Yes ❑ No
- ❑ Will member have liver function tests (LFTs) performed monthly? ❑ 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 #: ______________________________

REVISED/UPDATED: ~~7/26/2017; 12/23/2017;~~ **9/1/2018**