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: **Zelboraf™** (vemurafenib)

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

Drug Form/Strength: _____

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

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

RECOMMENDED DOSAGE: 960mg orally twice daily.

CLINICAL CRITERIA: To receive a **THREE (3) month approval**, boxes below **must** be checked. Medical notes/lab tests, 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 unresectable or metastatic melanoma with the serine-threonine protein kinase BRAF V600E mutation? ❑Yes ❑ No
- ❑ Was an FDA-approved test done to detect the presence of the BRAF V600E mutation? ❑Yes ❑ No **(Documentation required; include a copy of the test results with this request form)**
- ❑ Has baseline monitoring been completed, which includes electrocardiogram, electrolytes, liver enzymes, and bilirubin? **(Provide copy of labs)** ❑Yes ❑ No
- ❑ Has a baseline dermatologic evaluation been completed? ❑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:** ~~8/27/2017; 12/23/2017;~~ **9/1/2018**;