OPTIMA HEALTH COMMUNITY CARE

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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 1-844-348-3720. 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: Aliqopa® (copanlisib) **IV** (**J9999/C9399**) ***(Medical)***

DRUG INFORMATION: ***Complete all 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 MUST be checked to ensure authorization process will NOT be delayed.***

- ❑ Patient is age 18 years or older

AND

- ❑ The prescribing physician is an oncologist or hematologist

AND

- ❑ Patient has a diagnosis of relapsed follicular lymphoma, defined as having received at least two prior systemic therapies

****Dosage will be approved for 60mg administered as an intravenous infusion on Days 1, 8, and 15 of a 28 day cycle.****

Medication being provided by: ***Please check applicable box(es) below.***

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

OR

- ❑ **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 #: _____

***Approved by the Pharmacy and Therapeutic Committee**: 2/15/2018
REVISED/UPDATED: 6/26/2018