OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.***

Drug Requested: **Alunbrig**® (brigatinib) tablets

DRUG INFORMATION: ***Complete information below. If incomplete, authorization process will be delayed.***

Drug Form/Strength/Quantity per Day: ____

Dosing Schedule: ______________________________ **Length of Therapy:** ____________________

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

CLINICAL CRITERIA: ***To receive a THREE (3) month approval for this drug, ALL appropriate boxes below must be checked to qualify or authorization process will be delayed.***

Does member meet the following criteria?

- **Is Prescriber an oncologist?** ❑ Yes ❑ No
- Has member been diagnosed with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- If female, is member pregnant or breast feeding? ❑ Yes ❑ No
- If approved, initial prescription fill for 7 days' supply to ensure patient tolerance. ***Additional refills may be up to 34-days' supply.*** ❑ Yes ❑ No
- Accelerated approval – monitor for clinical benefit on tumor response. ❑ Yes ❑ No
- If approved, assess fasting blood glucose prior to therapy initiation and regularly during treatment. Monitor respiratory system function, blood pressure and heart rate after 2 weeks and then monthly thereafter. Monitor CPK and pancreatic enzymes regularly. ❑ Yes ❑ No
- Review drug profile for CYP3A inhibitors, CYP3A inducers, and hormonal contraceptives. ❑ Yes ❑ No

*****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: 12/23/2017