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: ***(check applicable box below)***

❑ **Erivedge®** (vismodegib)	❑ **Odomzo®** (sonidegib)

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:*** ____________

Maximum Quantity Allowed: 30 capsules for 30 days

***CLINICAL CRITERIA:* To receive a ONE (1) year approval for either Erivedge or Odomzo, ALL appropriate boxes below must be checked to qualify or authorization process will be delayed.**

Does member meet the following criteria?

❑ For **Erivedge®**:

- Member has been diagnosed with metastatic basal cell carcinoma? ❑ Yes ❑ No

  OR

- Member has a diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or is not a candidate for surgery and radiation? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- If female, patient is not pregnant. ❑ Yes ❑ No

❑ **Odomzo®**

- Member has a diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or radiation therapy, or those who are NOT candidates for surgery or radiation therapy? ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- If female, patient is not pregnant. ❑ Yes ❑ No
- Baseline serum creatine kinase and creatinine levels have been obtained? ❑ 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