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 form will delay authorization process.***

Drug Requested: Erleada™ (apalutamide) ***(Medicaid)***

***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***: _____

***Recommended dosage:* 240 mg (four 60 mg tablets) once daily**

***Quantity Limit:* 120 tablets/30 days**

***CLINICAL CRITERIA:* The following questions *MUST* be checked to ensure authorization process will *NOT* be delayed.**

Initial Approval Criteria: 6 months. All information below MUST be completed to qualify.

1. Does member have a diagnosis of NON-metastatic castration-resistant prostate cancer (nmCRPC)? **AND**
   ❑ Yes ❑ No
2. Is prescriber an oncologist? **AND** ❑ Yes ❑ No
3. Is member ≥ 18 years of age? **AND** ❑ Yes ❑ No
4. Member will receive a gonadotropin-releasing hormone (GnRH)-analog or the member has had a bilateral orchiectomy. ❑ Yes ❑ No

Renewal Approval Criteria: One (1) Year. All information MUST be completed to qualify.

1. Member continues to meet the above criteria? ❑ Yes ❑ No

   AND
2. There is tumor response with stabilization of disease or decrease in size of tumor or tumor spread.
   ❑ Yes ❑ No

   AND
3. Absence of unacceptable toxicity from the drug? *Examples of unacceptable toxicity include seizures, excessive falls and/or fractures, and any other Grade 3 or above side effects that are intolerable to the member?*
   ❑ 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: 7/1/2018