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: Farydak® (panobinstat)

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 SIX (6) month approval for this drug, ALL appropriate boxes below must be checked to qualify or authorization process will be delayed.

- **Prescriber is an:** ❑ **oncologist OR** ❑ **hematologist** ❑ Yes ❑ No
- **Does member meet the following criteria?**
  - Is member 18 years of age or older? ❑ Yes ❑ No
  - Diagnosis of relapsed multiple myeloma ❑ Yes ❑ No
  - Member has received at least two (2) prior regimens with bortezomib (Velcade®) and an immunomodulatory derivative (thalidomide (Thalomid®), lenalidomide (Revlimid®), or pomalidomide (Pomalyst®)? ❑ Yes ❑ No
  - State regimen and dates of therapy:

  Drug or Treatment Protocol Name: ______________________ ***Date received:*** ______________

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  - Member is concurrently receiving treatment with bortezomib (Velcade®) and dexamethasone? ❑ Yes ❑ No

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request or authorization process will be delayed.

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*****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