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: Gilotrif™ (afatinib)

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.

- Is medication being prescribed by an oncologist or a hematologist? ❑ Yes ❑ No
- Is patient 18 years old or older? ❑ Yes ❑ No
- Does member have the following diagnosis?
- Metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations? ❑ Yes ❑ No
- Has member tested positive for EGFR exon 19 deletions or exon 21 (L858R) substitution mutations with an FDA approved test? ***If YES, please provide testing results (Information on FDA-approved tests for the detection of EGFR mutations for NSCLC may be found at http://www.fda.gov/Companiondiagnostics)*** ❑ Yes ❑ No

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request.

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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