

OPTIMA HEALTH PLAN

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.*

(Form to be completed ONLY if the patient is self-administering.)

Drug Requested (select drug below):

<input type="checkbox"/> Granix® (TBO-filgrastim)	<input type="checkbox"/> Leukine® (sargramostim)	<input type="checkbox"/> Neupogen® (filgrastim)
<input type="checkbox"/> Neulasta® (PEG-filgrastim)	<input type="checkbox"/> Zarxio® (filgrastim)	

DRUG INFORMATION: Complete information below. Incomplete information will delay authorization process.

Drug Name/Form: _____ Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Chemotherapy Regimen: _____

******Documentation of CBC with differential test results must be submitted with this request, unless use is for prophylaxis.******

CLINICAL CRITERIA: ONE (1) of the following reasons below **MUST** be checked to qualify. Incomplete information will delay authorization process.

- Myelosuppressive chemotherapy in patients with nonmyeloid malignancies
- Bone Marrow Transplant
- Severe Chronic Neutropenia (ANC<1000 cells/mm³)
- Peripheral blood progenitor cell (PBPC) collection and therapy
- Acute myeloid leukemia (AML) receiving induction or consolidation chemotherapy
- Hepatitis C therapy related Neutropenia
- HIV/therapy related Neutropenia

Medication being provided by (check applicable box below):

Physician's office

OR

Specialty Pharmacy:

Sentara Norfolk General CM Pharmacy

(signature on next page)

****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: 8/26/2017.