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: ❑ **Ibrance**® (palbociclib)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy:** ______________

Diagnosis: ______________________ ***ICD Code, if applicable*:** ______________

CLINICAL CRITERIA: Box must be checked. Test results in chart documentation MUST BE INCLUDED with request. Incomplete information will delay authorization process.

❑ Hormone receptor-positive (HR+), human epidermal growth factor receptor 2-negative (HER2-) advanced or metastatic breast cancer that has spread to other parts of the body (metastatic).

Quantity limit: **Up to 21 doses per 28 days**

***Medication being provided by a Specialty Pharmacy*:** ❑ **PropriumRx**

*****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: ______________

Physician Name: ______________________________

Physician Signature: ______________________ Date: ______________

Office Contact Name: ______________________________

Phone Number: ______________________ Fax Number: ______________

DEA OR NPI #: ______________________________

***Approved by Pharmacy and Therapeutics Committee**: 7/16/2015;
REVISED/UPDATED: 7/26/2017;