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: **Iclusig®** (ponatinib)

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:*** _____

(NOTE: For either the CML or the Ph+ALL indication, the dose of Iclusig® is 45mg taken orally once daily.)

CLINICAL CRITERIA: ALL applicable boxes MUST be checked to qualify. Incomplete information will delay authorization process.

- ❑ Patient has a diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia resistant or intolerant to prior tyrosine kinase inhibitor therapy.

OR

- ❑ Patient has a diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia, resistant or intolerant to prior tyrosine kinase inhibitor therapy.

AND

- ❑ Trial and failure of :
  - ❑ imatinib (Gleevec)

***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: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED: 8/26/2017**