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 the authorization process.***

Drug Name: Iressa® (gefitinib)

DRUG INFORMATION: Please complete below. Incomplete information will delay the authorization process.

Drug Form/Strength/Month: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____**ICD Code:** _____

CLINICAL CRITERIA: All boxes MUST be checked to qualify. Lab results must be attached to this request. Incomplete data will delay the authorization process.

- ❑ Prescriber is an Oncologist
- ❑ Does member have metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) ❑ Yes ❑ No
- ❑ Laboratory test was submitted documenting exon 19 deletion or exon 21. (Therascreen EGFR RGQ PCR Kit) ❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy (Please check applicable box below):

❑ **For Optima Commercial Members:**
PropriumRx

❑ **For Optima Family Care Members:**
Sentara Norfolk General CM Pharmacy

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: 4/6/2018