

# 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:** Kisqali®-Femara® (ribociclib-letrozole)

**DRUG INFORMATION:** Complete all information below or authorization will be delayed.

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

**CLINICAL CRITERIA:** To receive a SIX (6) month approval for this drug, all boxes below must be checked to qualify to ensure authorization process will NOT be delayed. Chart notes/lab results MUST BE INCLUDED with this request.

• Does member meet the following criteria?

1. Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer who is receiving an aromatase inhibitor:  Yes  No

Please identify inhibitor below:

A. \_\_\_\_\_

B. \_\_\_\_\_

2. Is prescriber an oncologist?  Yes  No
3. Is member  $\geq$  18 years of age?  Yes  No
4. If female, is member pregnant or breast feeding?  Yes  No
5. If approved, monitor ECG and electrolytes prior to initiation of therapy, 14 days after first cycle, then at the beginning of each cycle for 6 cycles. Perform liver function tests before initiating therapy, every 2 weeks for the first 2 cycles and at the beginning of the next 4 cycles.
6. Review medication profile. Avoid CYP3A4 inhibitors, CYP3A inducers and drugs known to prolong QT interval.

**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 #: \_\_\_\_\_

REVISED/UPDATED: 6/23/2018; 7/18/2018