

# 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 forms will delay the authorization process.

**Drug Requested:** Lenvima® (lenvatinib) capsules

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

Drug Form/Strength/Quantity per Day: \_\_\_\_\_

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

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

**CLINICAL CRITERIA:** To receive a **SIX (6) month approval** for this drug, **ALL** appropriate boxes below **must** be checked to qualify or authorization process will be delayed.

Does member meet the following criteria?

- **Prescriber is an oncologist?**  Yes  No
- Is member 18 years of age or older?  Yes  No
- Diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer?  Yes  No
- Is member pregnant? (*Lenvima is embryotoxic. Advise of risk and use of contraception.*)  Yes  No

**MEDICAL NECESSITY:** Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request.

**\*\*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: 12/23/2017