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 ***(check applicable box below)*:**

❑ **Mekinist®** (trametinib)	❑ **Tafinlar®** (dabrafenib)

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

Drug Name: ________________________________

Drug Form/Strength/Quantity per Day: ________________________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________________

Diagnosis: ____________________ ***ICD Code, if applicable:*** ____________________

CLINICAL CRITERIA: To receive a THREE (3)-month approval for the drugs listed below, ALL appropriate lines MUST be checked to qualify. Authorization process will be delayed if not completed.

For Mekinist®: Medical notes/lab values/test results MUST be included with this request or authorization process will be delayed.

- Is drug being prescribed by an oncologist? ❑Yes ❑No
- Is patient 18 years old or older? ❑Yes ❑No
- Has member been diagnosed with unresectable or metastatic melanoma with BRAF V600E or V600K mutation? ❑Yes ❑ No
- Has mutation been detected/confirmed by a FDA-approved test? ❑Yes ❑No
  (Documentation required; include a copy of the test results with this fax)

For Tafinlar®: Medical notes/lab values/test results MUST be included with this request or authorization process will be delayed.

- Is drug being prescribed by an oncologist? ❑Yes ❑No
- Is member 8 years old or older? ❑Yes ❑No
- Does member have a diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation? ❑Yes ❑No
- Has member been diagnosed with a wild-type BRAF melanoma? ❑Yes ❑No
- Has mutation been detected/confirmed by a FDA-approved test? ❑Yes ❑No
  (Documentation required; include a copy of the test results with this fax.)
- Is patient pregnant? ❑Yes ❑No

*****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