OPTIMA HEALTH COMMUNITY CARE

PHARMACY/MEDICAL 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 1-844-348-3720. 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: **Neumega®** (oprelvekin) **(J2355)** ***(Medical)***

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

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

- ***Maximum treatment per chemotherapy cycle is 21 days and should be discontinued 2 days prior to next cycle or when platelet count is > 50,000 cells/mcL.***

CLINICAL CRITERIA: ***Check ALL appropriate criteria for approval of Neumega®. If incomplete, authorization process will be delayed.***

- ❑ Prescriber is an Oncologist.

AND

- ❑ Patient has solid tumor.

AND

- ❑ Patient has experienced severe thrombocytopenia (<50,000 cells/mcL) during previous chemotherapy documented by:

  Platelet count: _____ (cells/mcL)

AND

- ❑ Neumega is being used for the prevention of and not the treatment of thrombocytopenia.

Medication being provided by ***(check applicable box below):***

- ❑ **Physician's office**

OR

- ❑ **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: ~~8/1/2017;~~ **8/31/2017**;