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: Ninlaro® (ixazomib)

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?

- **Is prescriber an oncologist?** ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- Has member received at ***one (1)*** prior treatment for diagnosis? ❑ Yes ❑ No

  If YES, provide name of treatment regimen and dates of therapy below: ❑ Yes ❑ No

  Treatment _____ ***Date received:*** _____

  Treatment _____ ***Date received:*** _____

  Treatment _____ ***Date received:*** _____
- Will member be receiving both lenalidomide (Revlimid®) and dexamethasone? ❑ Yes ❑ No
- Has prior authorization request for lenalidomide (Revlimid®) been completed and approved? ❑ Yes ❑ No
- Will strong CYP3A inducers (i.e., rifampin, phenytoin, carbamazepine, St John's Wort) be administered concurrently? ❑ Yes ❑ No
- Is member receiving concurrent therapy with another proteasome inhibitor? ❑ Yes ❑ No
  Examples include: bortezomib (Velcade®), cafilzomib ((Kyprolis®) ***(list drugs below)***

_____

_____

*****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