

# OPTIMA HEALTH COMMUNITY CARE

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

Directions: The prescribing physician must sign and clearly print the 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:**      **Stivarga®** (regorafenib)

**DRUG INFORMATION:** Please complete information below. Incomplete information will delay authorization process.

**Drug Form/Strength/Quantity:** \_\_\_\_\_

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

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

**Dosage/Administration Recommendation:** The recommended dose is 160 mg (four 40 mg tablets) taken orally once daily, with a low-fat breakfast, for the first 21 days of each 28 day cycle

**CLINICAL CRITERIA:** Please complete below. **ALL** applicable lines **must** be completed to qualify. Incomplete information will delay authorization process.

Patient has metastatic colorectal cancer (mCRC)

Patient has been previously treated with:

FOLFOXIRI (folinic acid, 5-fluorouracil, oxaliplatin, and irinotecan)

**AND**

Anti-VEGF therapy (e.g., bevacizumab) **OR**  Anti-EGFR therapy (e.g., panitumumab or cetuximab) **if** KRAS wild type mCRC

**OR**

Patient has advanced gastrointestinal stromal tumor (GIST)

Tumor cannot be surgically removed **OR**  Cancer is metastatic

Tumor is no longer responsive to imatinib (Gleevec) and sunitinib (Sutent)

**OR**

Patient has hepatocellular carcinoma (HCC) who have been previously treated with sorafenib.

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

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_      Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_      Fax Number: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_