

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: Xalkori™ (crizotinib)

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

Drug Form/Strength: _____

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

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

RECOMMENDED DOSAGE: 200mg or 250mg orally twice daily.

CLINICAL CRITERIA: To receive a **THREE (3) month approval**, boxes below **must** be checked. Medical charts/test results, etc. **MUST** be attached with this request or authorization will be delayed.

- Prescriber is an Oncologist? Yes No
- Does member have a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC)? Yes No
- Is member anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test?
(If YES, please provide chart notes documenting that member is ALK-positive) Yes No
- Will member have liver function tests (LFTs) performed monthly? Yes No

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 #: _____

REVISED/UPDATED: 7/26/2017; 12/23/2017;