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: Zydelig® (idelalisib)

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.

- **Is medication being prescribed by: ❑ oncologist OR ❑ hematologist** ❑ Yes ❑ No
- Is member 18 years of age or older? ❑ Yes ❑ No
- Does member have ***one (1)*** of the following diagnoses? ❑ Yes ❑ No
  - Relapsed chronic lymphocytic leukemia (CLL) and must be used in combination with rituximab? ❑ Yes ❑ No

    OR
  - Relapsed follicular B-cell non-Hodgkin lymphoma (FL) **and** has received at least **two** prior therapies? ❑Yes ❑ No

    OR
  - Relapsed small lymphocytic lymphoma (SLL) **and** has received at least **two** prior therapies ❑ Yes ❑ No

Prior Therapies for FL

Drug or Treatment Protocol Name: ______________________ *Date received:* ______________

Drug or Treatment Protocol Name: ______________________ *Date received:* ______________

Prior Therapies for SLL

Drug or Treatment Protocol Name: ______________________ *Date received:* ______________

Drug or Treatment Protocol Name: ______________________ *Date received:* ______________

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request.

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*****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