OPTIMA HEALTH PLAN

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 1-800-750-9692. 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 ***(select applicable drug below)*:**

❑ **Ibrance®** (palbociclib)	❑ **Kisqali®** (ribociclib)

DRUG INFORMATION: Complete below. Incomplete information will delay the authorization process.

Drug Name/Form: _____ **Strength/Quantity**: _____

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

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

***Quantity Limit*:** **Up to 21 doses per 28 days**

CLINICAL CRITERIA: Complete ALL boxes must be checked to qualify. Test results in chart documentation MUST be included with this form or authorization process will be delayed.

- ❑ Hormone receptor-positive (HR+), human epidermal growth factor receptor 2-negative (HER2-) advanced or metastatic breast cancer that has spread to other parts of the body (metastatic).

***Medication being provided by a Specialty Pharmacy*:** ❑ **Briova SpecialtyRx**

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 7/16/2015;
REVISED/UPDATED: ~~8/11/2015; 12/28/2015; 4/17/16; 5/6/2016; 7/11/2016; 9/22/2016; 12/11/2016; 6/8/2017; 8/4/2017;~~ **9/14/2017**;