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: **Rubraca™** (rucaparib)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

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

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

Recommended dose: 600 mg (two 300 mg tablets twice daily

CLINICAL CRITERIA: ALL information below MUST be checked to qualify or authorization process will be delayed. Chart notes, labs, and tests MUST be submitted with this request.

- ❑ **Prescriber is an Oncologist**
  - ❑ Diagnosed as monotherapy for the treatment of patients with deleterious *BRCA* mutation associated advanced ovarian cancer who have been treated with two or more chemotherapies.
  - ❑ Include tests (i.e. Foundation Focus™ CDx*BRCA* test)
    - ❑ Germline mutation
    - ❑ Somatic mutation
    - ❑ Other mutation: _____ ***(provide literature to support drug)***

Medication being provided by (check applicable box below):

- ❑ **Physician's office**

OR

- ❑ **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**: 8/17/2017
REVISED/UPDATED: 9/28/2017