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: **Sutent**® (sunitinib)

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:*** _____

CLINICAL CRITERIA: ***Applicable box MUST be checked to qualify. Incomplete information will delay authorization process.***

- ❑ Patient has a diagnosis of gastrointestinal stromal tumor (GIST) following failure of or intolerance to imatinib (Gleevec®).

OR

- ❑ Patient has a diagnosis of advanced renal cell carcinoma.

***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**: 1/17/2008
REVISED/UPDATED: ~~6/10/2011~~; ~~9/8/2011~~; ~~11/25/2011~~; ~~8/18/2014~~; ~~9/23/2014~~; ~~11/5/2014~~; ~~5/22/2015~~; ~~12/29/2015~~; ~~9/22/2016~~; ~~11/29/2016~~; ~~12/13/2016~~; ~~9/18/2017~~; **10/7/2017**;