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: **Tagrisso**™ (osimertinib)

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: Boxes MUST be checked to qualify. Incomplete information will delay authorization process.

- ❑ Does the member have Tumor T790M EGFR mutation status ***(please submit tumor biopsy or plasma specimen)***? ❑ Yes ❑ No
- ❑ Does the member have non-small cell lung cancer, metastatic (T790M EGFR)? ❑ Yes ❑ No

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:** 1/19/2017
REVISED/UPDATED: ~~3/28/2017~~; ~~9/18/2017~~; **10/7/2017**;