

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: Zykadia™ (ceritinib)

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. If **NOT** checked, authorization process will be delayed.

- Patient has a diagnosis of metastatic non-small cell lung cancer
- Documented copy of ALK-positive mutation, as detected by an FDA-approved test (i.e., Vysis ALK Break-Apart Fish Probe Kit)

AND

- Trial and failure of:
 - crizotinib (Xalkori®)

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: 10/16/2014

REVISED/UPDATED: 11/20/2014; 1/2/2015; 5/22/2015; 12/29/2015; 9/22/2016; 11/29/2016; 12/14/2016; 9/18/2017; 10/7/2017