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. If information provided is **NOT** complete, correct, or legible, authorization will be delayed.

Form to be completed ONLY if the patient is self-administering.

Drug Requested (select drug below that applies):

❑ **Granix®** (TBO-filgrastim)	❑ **Leukine®** (sargramostim)	❑ **Neupogen®** (filgrastim)
❑ **Neulasta®** (PEG-filgrastim)	❑ **Zarxio®** (filgrastim)	❑ **Udenyca®** (pegfilgrastim-cbqv)
❑ **Fulphila™** (pegfilgrastim-jmdb)	❑ **Nivestym™** (filgrastim-aafi)	

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

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

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

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

Chemotherapy Regimen: _____

***** Documentation of CBC with differential test results must be submitted with request, unless use is for prophylaxis. *****

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

- ❑ Myelosuppressive chemotherapy in patients with nonmyeloid malignancies
- ❑ Bone Marrow Transplant
- ❑ Severe Chronic Neutropenia (ANC<1000 cells/mm^3)
- ❑ Peripheral blood progenitor cell (PBPC) collection and therapy
- ❑ Acute myeloid leukemia (AML) receiving induction or consolidation chemotherapy
- ❑ Hepatitis C therapy related Neutropenia
- ❑ HIV/therapy related Neutropenia

Medication being provided by (check box below that applies):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

(Continued on next page; signature page MUST be attached to request)

(Signature page MUST be included with form)

***** 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.****

Member 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:**
REVISED/UPDATED: ~~2/9/2009; 6/14/2011; 8/19/2011; 1/23/2012; 1/14/2014; 4/9/2014; 5/7/2014; 5/28/2014; 8/13/2014; 10/31/2014; 5/21/2015~~; ~~12/27/2015~~; ~~6/9/2016; 8/19/2016; 9/22/2016; 12/11/2016; 8/3/2017; 5/14/2019;~~ **8/6/2019**