

OPTIMA HEALTH PLAN

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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 1-844-723-2094. 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: Aliqopa® (copanlisib) IV (J9999/C9399) (Medical)

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

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: All boxes **MUST** be checked to ensure authorization process will **NOT** be delayed.

- Patient is age 18 years or older

AND

- The prescribing physician is an oncologist or hematologist

AND

- Patient has a diagnosis of relapsed follicular lymphoma, defined as having received at least two prior systemic therapies

Dosage will be approved for 60mg administered as an intravenous infusion on Days 1, 8, and 15 of a 28 day cycle.

Medication being provided by: Please check applicable box(es) below.

- Location/site of drug administration: _____
NPI or DEA # of administering location: _____

OR

- Specialty Pharmacy: PropriumRx

*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 the Pharmacy and Therapeutic Committee: 2/15/2018

REVISED/UPDATED: 6/26/2018