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.***

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

Drug Requested ***(select drug below):***

❑ **Granix®** (TBO-filgrastim)	❑ **Leukine®** (sargramostim)	❑ **Neupogen®** (filgrastim)
❑ **Neulasta®** (PEG-filgrastim)	❑ **Zarxio®** (filgrastim)	

DRUG INFORMATION: Complete information below. Incomplete information will delay authorization process.

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

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

Diagnosis: _____ **ICD Code:** _____

Chemotherapy Regimen: _____

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

CLINICAL CRITERIA: ONE (1) of the following reasons below MUST be checked to qualify. Incomplete information will delay authorization process.

- ❑ 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 applicable box below)*:**

- ❑ **Physician's office**

OR

- ❑ **Specialty Pharmacy**:

For Optima Commercial Members:

- ❑ **PropriumRx**

For Optima Family Care Members:

- ❑ **Sentara Norfolk General CM Pharmacy**

(signature on next page)

*****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:**
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**