

# 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 (select applicable drug below):

**Ibrance®** (palbociclib)

**Kisqali®** (ribociclib)

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

Drug Name/Form: \_\_\_\_\_ Strength/Quantity: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Quantity Limit: Up to 21 doses per 28 days

**CLINICAL CRITERIA:** Complete ALL boxes must be checked to qualify. Test results in chart documentation MUST be included with this form or authorization process will be delayed.

- Hormone receptor-positive (HR+), human epidermal growth factor receptor 2-negative (HER2-) advanced or metastatic breast cancer that has spread to other parts of the body (metastatic).

**Medication being provided by a 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 Pharmacy and Therapeutics Committee: 7/16/2015;

REVISED/UPDATED: 8/11/2015; 12/28/2015; 4/17/16; 5/6/2016; 7/11/2016; 9/22/2016; 12/11/2016; 6/8/2017; 8/4/2017; 9/14/2017.