

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: Iclusig® (ponatinib)

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: _____

(NOTE: For either the CML or the Ph+ALL indication, the dose of Iclusig® is 45mg taken orally once daily with or without food.)

CLINICAL CRITERIA: ALL applicable boxes MUST be checked to qualify. Incomplete information will delay authorization process.

- Patient has a diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia resistant or intolerant to prior tyrosine kinase inhibitor therapy.

OR

- Patient has a diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia, resistant or intolerant to prior tyrosine kinase inhibitor therapy.

AND

- Trial and failure of :
 imatinib (Gleevec)

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: 7/18/2013

REVISED/UPDATED: 9/30/2013; 4/7/2014; 8/13/2014; 9/24/2014; 10/31/2014; 5/21/2015; 12/28/2015; 9/22/2016; 12/11/2016; 8/4/2017.