

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: **Rubraca™ (rucaparib)**

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

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Recommended dose: 600 mg (two 300 mg tablets twice daily)

CLINICAL CRITERIA: ALL information below MUST be checked to qualify or authorization process will be delayed. Chart notes, labs, and tests MUST be submitted with this request.

Prescriber is an Oncologist

Diagnosed as monotherapy for the treatment of patients with deleterious *BRCA* mutation associated advanced ovarian cancer who have been treated with two or more chemotherapies.

Include tests (i.e. Foundation Focus™ CDx*BRCA* test)

Germline mutation

Somatic mutation

Other mutation: _____ (provide literature to support drug)

Medication being provided by (check applicable box below):

Physician's office

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 Pharmacy and Therapeutics Committee: 8/17/2017
REVISED/UPDATED: 9/28/2017