

# 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:**        **Zelboraf™** (vemurafenib)

**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: \_\_\_\_\_

Dosing: Zelboraf™ 240 mg: \_\_\_\_\_

**RECOMMENDED DOSAGE:** 960mg orally twice daily. Dosage reductions to 720mg or 480mg twice daily have been recommended in patients developing severe adverse events.

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

- Patient has diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation.
- Documented copy of BRAF mutation-positive, as detected by an FDA approved test.

**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: 2/15/2007

REVISED/UPDATED: 9/9/2011; 4/2/2012; 9/24/2014; 11/6/2014; 5/22/2015; 12/29/2015; 9/22/2016; 12/11/2016; 8/5/2017.