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 all information below or 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**.**

OR

- ❑ Patient has diagnosis of Erdheim-Chester disease with BRAF V600 mutation.

AND

- ❑ A copy of BRAF mutation-positive test result has been submitted ***(test results MUST be submitted with request)***

***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~~ **2/15/2018**
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;~~ **6/28/2018**