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: **Zykadia**™ (ceritinib)

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:*** ____________

CLINICAL CRITERIA: Boxes MUST be checked to qualify. If NOT checked, authorization process will be delayed.

- ❑ Patient has a diagnosis of metastatic non-small cell lung cancer
- ❑ Documented copy of ALK-positive mutation, as detected by an FDA-approved test (i.e. Vysis ALK Break-Apart Fish Probe Kit)

***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:** 10/16/2014
REVISED/UPDATED: ~~11/20/2014; 1/2/2015; 5/22/2015; 12/29/2015; 9/22/2016; 12/11/2016; 8/5/2017;~~ **11/24/2017**;