OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY 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 forms will delay the authorization process.***

Drug Requested: **Gilenya®** (dalfampridine) (***Preferred***) ***(MEDICAID)***

Preferred Drugs	***Non-Preferred Drugs***
❑ **Avonex®** ❑ **Avonex® Adm Pack** ❑ **Betaseron®** ❑ **Copaxone® 20 mg syringe®** ❑ **Gilenya® *(SE)*** ❑ **Rebif® SQ** ❑ **Rebif® Rebi dose Pen®**	❑ Ampyra® ❑ Aubagio® ❑ Copaxone® **40 mg syringe®** ❑ Extavia® Kit ❑ Glatopa™ ❑ Plegridy® ❑ Tecfidera™ ❑ Zinbryta™ ***(QL)***

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

Dosage Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

CLINICAL CRITERIA: The following criteria MUST be met to ensure the authorization process will NOT be delayed.

- Trial and failure of a ***Preferred*** injectable is required for Gilenya approval.
- Trial and failure of a ***Preferred*** injectable drug ❑ Yes ❑ No
  - If ***Yes,*** provide drug name/form/strength. _____
- If receiving a ***non-preferred oral drug,*** both an injectable preferred ***AND*** Gilenya must have been tried and failed***.***

❑ Yes ❑ No

List drug(s) tried and failed:

_____

_____

MEDICAL NECESSITY: Provide clinical evidence that the Preferred injectable drug will not provide adequate benefit.

_____

_____

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 #: _____

REVISED/UPDATED: 7/1/2018