OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/MEDICAL 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 1-844-723-2094. 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: **Lemtrada®** (alemtuzumab) **(J0202)** ***(Medical)***

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

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

When approved, the covered dose is 5 infusions during Year 1 (12 mg daily on 5 consecutive days), followed by 3 infusions in Year 2 (12 mg daily on 3 consecutive days). Subsequent infusions (Year 3 and beyond) of 12 mg daily on 3 consecutive days may be approved based on medical necessity.

CLINICAL CRITERIA: All boxes that apply must be checked to ensure authorization process will NOT be delayed.

To qualify, medical/chart notes MUST be submitted with form to support each line checked.

For MS indication, check ALL below. If incomplete, authorization process will be delayed.

- ❑ Prescriber is a Neurologist
- ❑ Patient has a confirmed diagnosis of relapsing-remitting MS
- ❑ Patient has had at least one medically documented clinical relapse within 12 months
- ❑ The provider is registered with the Lemtrada® REMS program
- ❑ Patient has completed a trial and has failed at least ***TWO (2)*** of the following agents ***(check ALL tried):***

❑ Aubagio® (teriflunomide)	❑ Plegridy® (pegylated-IFN beta-1a)
❑ Avonex® (IFN beta-1b)	❑ Gilenya® (fingolimod)
❑ Betaseron® (IFN beta-1a)	❑ Rebif® (IFN beta-1a)
❑ Copaxone® (glatiramer acetate)	❑ Tecfidera® (dimethyl fumarate)
❑ Extavia® (IFN beta-1a)	❑ Tysabri® (natalizumab)

(continued on next page)

For Infusions Year 3 and beyond, check below all of the following:

- ❑ Prescriber is a Neurologist
- ❑ Patient has a confirmed diagnosis of relapsing-remitting MS
- ❑ Patient's last Lemtrada® infusion was at least 12 months ago
- ❑ Patient has had at least one medically documented clinical relapse within 12 months with disease progression ***(chart notes must be submitted)***
- ❑ The provider is registered with the Lemtrada® REMS program

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 #: _____ Fax #: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018