OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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)**

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

DRUG INFORMATION: Complete 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 authorization will NOT be delayed.

- Trial and failure of a **Preferred** injectable is required for Gilenya approval. ❑ Yes ❑ No
- 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.

_____

_____

(continued on next page)

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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: ~~7/6/2017~~; ~~8/29/2017~~; **8/20/2018**