OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 1-844-348-3720**. 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 - ALL boxes below MUST be checked to qualify. If not completed, authorization 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):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  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 Number: _____ Fax #: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~8/1/2017; 8/24/2018;~~ **10/8/2018**