

OPTIMA HEALTH 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 1-844-723-2094.** 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 - 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**):

<input type="checkbox"/> Aubagio [®] (teriflunomide)	<input type="checkbox"/> Plegridy [®] (pegylated-IFN beta-1a)
<input type="checkbox"/> Avonex [®] (IFN beta-1b)	<input type="checkbox"/> Gilenya [®] (fingolimod)
<input type="checkbox"/> Betaseron [®] (IFN beta-1a)	<input type="checkbox"/> Rebif [®] (IFN beta-1a)
<input type="checkbox"/> Copaxone [®] (glatiramer acetate)	<input type="checkbox"/> Tecfidera [®] (dimethyl fumarate)
<input type="checkbox"/> Extavia [®] (IFN beta-1a)	<input type="checkbox"/> Tysabri [®] (natalizumab)

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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.~~ (Reformatted) 2/5/2019.