OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZAION/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. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Multiple Sclerosis Drugs

Drug Requested – check below the drug that applies:

PREFERRED Drugs		
❑ **Avonex®**	❑ **Avonex® Adm Pack**	❑ **Betaseron®**
❑ **Copaxone® 20 mg syringe®**	❑ **Gilenya® (SE)**	❑ **Rebif® SQ**
❑ **Rebif® Rebidose Pen®**		
Non-Preferred Drugs		
❑ **Ampyra®** (PA required)**	❑ **Aubagio®**	❑ **Copaxone® (40 mg syringe®)**
❑ **dalfampridine ER (generic for Ampyra®)**	❑ **Extavia® Kit**	❑ **Glatopa™**
❑ **Plegridy®**	❑ **Tecfidera™**	❑ **Zinbryta® (QL)**

(Please note: see Ampyra® PA form)**

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

Dosage Form/Strength: _____

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

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

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

Step-Edit for Gilenya®:

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

   If **YES,** provide drug name/form/strength. _____

2. To receive a **non-preferred oral drug,** both an injectable preferred **AND** Gilenya® must have been tried and failed**.** ❑ Yes ❑ No

(Continued on next page)

3. 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: ~~7/6/2017~~; ~~8/29/2017~~; ~~8/20/2018~~; ~~(corrected) 2/27/2019~~; ~~(Reformatted) 4/18/2019~~; **6/15/2019**