OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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: Ocrevus™ (ocrelizumab) **Injection (J-2350/C9494) (Medical) (Non-Preferred)**

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

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

RECOMMENDED DOSAGE AND ADMINISTRATION:

INITIAL DOSE: 300 mg intravenous infusion, followed 2 weeks later by a 2nd 300 mg intravenous infusion

SUBSEQUENT DOSES: single 600 mg intravenous infusion every 6 months

Medical notes MUST be submitted with this request to support each line checked.

CLINICAL CRITERIA: **All** boxes that apply **MUST** be checked to qualify. Incomplete information or medical notes are **not** attached with this form request will delay the authorization process.

PRIMARY PROGRESSIVE Multiple Sclerosis (MS) indication. Please check below **all** that apply. If **NOT** checked, authorization process will be delayed. Medical notes **MUST** be attached with this request.

- ❑ Prescriber is a **Neurologist**
- ❑ Patient has a **confirmed** diagnosis of **Primary Progressive MS**

RELAPSING REMITTING MS indication. Please check **all** below **ALL** that apply. If **NOT** checked, authorization process will be delayed. Medical notes **MUST** be attached with this request.

- ❑ 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
- ❑ Patient has completed a trial and has failed at least **TWO (2)** of the following agents: **(check each that have been tried):**

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

(signature on next page and must be attached with this request)

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 Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~8/1/2017; 12/27/2017; 8/28/2018; 9/28/2018;~~ **10/9/2018**