

# OPTIMA HEALTH COMMUNITY 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:** 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 2<sup>nd</sup> 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):**

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

(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; (Reformatted) 2/6/2019.