

**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: Tysabri® (natalizumab) (J-2323) (Medical)

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

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: Check **all** boxes below that apply for specific diagnosis. If **NOT** checked or incomplete, authorization may be delayed.

Please check all below for MS indication:

- 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 is registered with the Tysabri® risk management program known as TOUCH™
- Patient has completed a trial and has failed at least **ONE (1)** of the following agents:

(Check all tried)

- Aubagio® (teriflunomide)
- Avonex® (IFN beta-1b)
- Betaseron® (IFN beta-1a)
- Copaxone® (glatiramer acetate)
- Extavia® (IFN beta-1a)
- Gilenya® (fingolimod)
- Plegridy® (peginterferon beta-1a)
- Rebif® (IFN beta-1a)
- Tecfidera® (dimethyl fumarate)

OR

- Patient's current or potential disease progression warrants the use of Tysabri®

Please check all below for Crohn's indication:

- Prescriber is a Gastroenterologist
- Patient has moderate to severe active Crohn's disease with evidence of inflammation
- Patient is registered with the Tysabri® risk management program known as CD TOUCH™

- Patient has had failure of conventional therapies: Budesonide or high dose steroids (prednisone 40-60mg)

Trial and Failure of all:

- Remicade®
- AND**
- Humira®

(continued on next page)

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 Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 8/1/2017; 5/25/2018; 8/31/2018; 10/8/2018