

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

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

**DIAGNOSIS – MS Indication:** check **ALL** below that apply.

- 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**):

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

**OR**

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

**DIAGNOSIS – CROHN'S Indication:** check **ALL** below that apply

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**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)

**OR**

- Trial and Failure of:                       Renflexis®                      **AND**                       Humira®

**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 #:** \_\_\_\_\_

\*Approved by Pharmacy and Therapeutics Committee: 3/20/2008

REVISED/UPDATED: 7/16/2009; 6/3/2011; 9/9/2011; 5/2/2012; 7/2/2012; 9/10/2012; 2/21/2013; 6/30/13; 5/8/2014; 8/18/2014; 10/31/2014; 4/3/2015; 5/23/2015; 12/30/2015; 1/29/2016; 7/18/2016; 9/22/2016; 12/11/2016; 7/24/2017; 9/18/2017; 7/10/2018; 1/25/2019; (REFORMATTED) 2/5/2019