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: **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)**:

❑ 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®

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

(continued on next page)

- ❑ **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**