OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete forms will delay the authorization process.**

Drug Requested: Zinbryta® (daclizumab) **Injection (Non-Preferred)**

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

Dosage Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Quantity Limit – 1 ml per 28 days (0.036 ml per day)

CLINICAL CRITERIA: The following criteria **MUST** be met to qualify or authorization may be delayed.

- Does the patient have a diagnosis of relapsing forms of Multiple Sclerosis (MS) (ICD-9 code = 340)? ❑ Yes ❑ No
  - If ***No***, please provide diagnosis: _____
- Is the patient a minimum of 17 years of age? ❑ Yes ❑ No
- Has the patient tried and failed at least 2 or more MS drugs? ❑ Yes ❑ No
  If ***Yes,*** list the drugs below in the space provided.
- Does the patient have a pre-existing hepatic disease or hepatic impairment? ❑ Yes ❑ No
  (Zinbryta® is contraindicated in patients who have pre-existing hepatic disease or hepatic impairment.)

List pharmaceutical drugs attempted and outcome:

1. _____
2. _____
3. _____

MEDICAL NECESSITY: Provide clinical evidence that the **Preferred** drug(s) will not provide adequate benefit:

_____

_____

Medication being provided by a Specialty Pharmacy - PropriumRx

(Continued on next page; signature page MUST be attached to request.)

(Signature page MUST be included with this request.)

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: ~~6/30/2017; 9/1/2017;~~ **9/1/2018**