OPTIMA HEALTH COMMUNITY CARE

PHARMACY 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 1-800-319-5003. 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: **Gilenya®** (dalfampridine) (***Preferred***) **MEDICAID**

Preferred Drugs	***Non-Preferred Drugs***
❑ **Avonex®** ❑ **Avonex® Adm Pack** ❑ **Betaseron®**	❑ Ampyra® ❑ Aubagio® ❑ Copaxone® **40 mg syringe®**
❑ **Copaxone® 20 mg syringe®** ❑ **Gilenya®** ***(SE)***	❑ Extavia® Kit ❑ Glatopa™ ❑ Plegridy®
❑ **Rebif® SQ** ❑ **Rebif® Rebi dose Pen®**	❑ Tecfidera™ ❑ Zinbryta™ ***(QL)***

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Dosage Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy**: ______________________

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

CLINICAL CRITERIA: The following criteria MUST be met or authorization process will be delayed.

- Trial and failure of a **Preferred** injectable is required for Gilenya approval.
- Trial and failure of a **Preferred** injectable drug ❑ Yes ❑ No
  - If ***Yes*****,** provide drug name/form/strength. ______________________
- If receiving a ***non-preferred oral drug,*** both an injectable preferred ***AND*** Gilenya must have been tried and failed. ❑ Yes ❑ No

List drug(s) tried and failed:

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MEDICAL NECESSITY**:** ***Provide clinical evidence that the Preferred injectable drug will not provide adequate benefit.***

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Medication being provided by a 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: ~~7/6/2017;~~ **8/29/2017**