

OPTIMA HEALTH COMMUNITY CARE

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: **Lemtrada® (alemtuzumab) (J0202) (Medical)**

DRUG INFORMATION: Complete all information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

When approved, the covered dose is 5 infusions during Year 1 (12 mg daily on 5 consecutive days), followed by 3 infusions in Year 2 (12 mg daily on 3 consecutive days). Subsequent infusions (Year 3 and beyond) of 12 mg daily on 3 consecutive days may be approved based on medical necessity.

CLINICAL CRITERIA: All boxes that apply **must** be checked. Incomplete information will delay the authorization process.

To qualify, medical/chart notes **MUST** be submitted with form to support each line checked.

For MS indication, check ALL below. If incomplete, authorization process will be delayed.

- 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
- The provider is registered with the Lemtrada® REMS program
- Patient has completed a trial and has failed at least **TWO (2)** of the following agents (**check ALL tried**):

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

(continued on next page)

For Infusions Year 3 and beyond, check below all of the following:

- Prescriber is a Neurologist
- Patient has a confirmed diagnosis of relapsing-remitting MS
- Patient's last Lemtrada® infusion was at least 12 months ago
- Patient has had at least one medically documented clinical relapse within 12 months with disease progression (*chart notes must be submitted*)
- The provider is registered with the Lemtrada® REMS program

Medication being provided by (check applicable box below):

Physician's office

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 #: _____ Fax #: _____

DEA OR NPI #: _____

REVISED/UPDATED: 8/1/2017