OPTIMA HEALTH COMMUNITY CARE

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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: Ocrevus™ (ocrelizumab) **Injection (J-2350/C9494)** ***(Medical)*** ***(Non-Preferred)***

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

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

RECOMMENDED DOSAGE AND ADMINISTRATION:

INITIAL DOSE: 300 mg intravenous infusion, followed 2 weeks later by a 2nd 300 mg intravenous infusion
SUBSEQUENT DOSES: single 600 mg intravenous infusion every 6 months

Medical notes MUST be submitted with this request to support each line checked.

CLINICAL CRITERIA: All boxes that apply MUST be checked to qualify. Incomplete information or medical notes are not attached with this form request will delay the authorization process.

Please check all below for Primary Progressive MS indication. If NOT checked, authorization process will be delayed. Medical notes MUST be attached with this request.

- ❑ Prescriber is a **Neurologist**
- ❑ Patient has a ***confirmed*** diagnosis of ***Primary Progressive MS***

Please check all below for Relapsing-Remitting MS indication. If NOT checked, authorization process will be delayed. Medical notes MUST be attached with this request.

- ❑ 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 has completed a trial and has failed at least **TWO (2)** of the following agents: ***(check each that have been tried):***

❑ Aubagio® (teriflunomide)	❑ Betaseron® (IFN beta-1a)	❑ Extavia® (IFN beta-1a)
❑ Avonex® (IFN beta-1b)	❑ Copaxone® (glatiramer acetate)	❑ Gilenya® (fingolimod)
❑ Lemtrada® (alemtuzumab)	❑ Rebif® (IFN beta-1a)	❑ Plegridy® (pegylated-IFN beta-1a)
❑ Tecfidera® (dimethyl fumarate)	❑ Tysabri® (natalizumab)	

(signature on next page)

***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 Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~8/1/2017;~~ **12/27/2017**;