# OPTIMA HEALTH COMMUNITY CARE

## 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 1-844-348-3720. 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-3590)** ***(Medical)*** ***(Non-Preferred)***

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

**Drug Form/Strength:** _____

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

**Diagnosis:** _____ ***ICD Code:*** _____

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

***CLINICAL CRITERIA: Check ALL that apply. Boxes must be checked to qualify or authorization process will be delayed.***

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

- ❑ ***Relapsing-Remitting MS indication:***
  - ❑ 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)
    - ❑ Avonex® (IFN beta-1b)
    - ❑ Betaseron® (IFN beta-1a)
    - ❑ Copaxone® (glatiramer acetate)
    - ❑ Extavia® (IFN beta-1a)
    - ❑ Gilenya® (fingolimod)
    - ❑ Lemtrada® (alemtuzumab)
    - ❑ Plegridy® (pegylated-IFN beta-1a)
    - ❑ Rebif® (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**