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: Tysabri® (natalizumab) **(J-2323)** ***(Medical)***

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

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: Check all boxes below that apply for specific diagnosis. If NOT checked or incomplete, authorization process will be delayed.

Please check all below for 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 is registered with the Tysabri® risk management program known as TOUCH™
- ❑ Patient has completed a trial and has failed at least **ONE (1)** of the following agents:

(Check all tried)

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

OR

- ❑ Patient's current or potential disease progression warrants the use of Tysabri®

Please check all below for Crohn's indication:

- ❑ Prescriber is a Gastroenterologist
- ❑ Patient has moderate to severe active Crohn's disease with evidence of inflammation
- ❑ Patient is registered with the Tysabri® risk management program known as CD TOUCH™
- ❑ Patient has had failure of conventional therapies: Budesonide or high dose steroids (prednisone 40-60mg)
- ❑ **Trial and Failure of all:**
  - ❑ Remicade®

  AND
  - ❑ Humira®

(continued on next page)

***Medication being provided by** (check applicable box below)*:

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  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;~~ **5/25/2018**