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 1-800-319-5003. 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: **Zinbryta®** (daclizumab) **Inj** ***(Non-Preferred)*** **MEDICAID**

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:*** _____

Quantity Limit **– 1 ml per 28 days (0.036 ml per day)**

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

- Does the patient have a diagnosis of relapsing forms of Multiple Sclerosis (MS) (ICD-9 code = 340)? ❑ Yes ❑ No
  - If ***No***, please provide diagnosis: _____
- Is the patient a minimum of 17 years of age? ❑ Yes ❑ No
- Has the patient tried and failed at least 2 or more MS drugs? ❑ Yes ❑ No
  If ***Yes,*** list the drugs below in the space provided.
- Does the patient have a pre-existing hepatic disease or hepatic impairment? ❑ Yes ❑ No
  (Zinbryta® is contraindicated in patients who have pre-existing hepatic disease or hepatic impairment.)

List pharmaceutical drugs attempted and outcome:

1. _____
2. _____
3. _____

MEDICAL NECESSITY: Provide clinical evidence that the preferred drug(s) will not provide adequate benefit:

_____

_____

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: ~~6/30/2017,~~ **9/1/2017**