OPTIMA HEALTH PLAN

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 1-800-750-9692. 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: **Glatopa™** (glatiramer acetate)

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

Drug Form/Strength: _____

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

Diagnosis: _____ ***ICD Code, if applicable:*** _____

- ***Glatopa™ is a therapeutically equivalent and can be substituted for Copaxone® 20 mg injection.***

CLINICAL CRITERIA: Boxes MUST be checked to qualify. Incomplete information will delay authorization process.

- ❑ Physician is a Neurologist

AND

- ❑ Patient must have documentation of trial and failure of Copaxone® 20 mg

Medication being provided by a Specialty Pharmacy: ❑ **Briova SpecialtyRx**

*****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 #: _____

***Approved by the Pharmacy and Therapeutic Committee**: 8/20/2015
REVISED/UPDATED: ~~10/26/2015~~; ~~12/22/2015~~; ~~8/25/2016~~; ~~9/22/2016~~; ~~11/17/2016~~; ~~12/12/2016~~; ~~9/14/2017~~; **10/6/2017**;