

# OPTIMA HEALTH PLAN

## 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 1-844-202-5034. 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:** Lemtrada® (alemtuzumab) (J0202) (Medical)

**DRUG INFORMATION:** Complete all information below or authorization process will be delayed.

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

When approved, the covered dose is **5 infusions during Year 1** (12 mg daily on 5 consecutive days), followed by **3 infusions in Year 2** (12 mg daily on 3 consecutive days). Subsequent infusions (Year 3 and beyond) of 12 mg daily on 3 consecutive days may be approved based on medical necessity.

**CLINICAL CRITERIA:** All applicable boxes **must** be checked to ensure authorization process will **NOT** be delayed.

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

**For MS indication, ALL boxes below MUST be checked to qualify to ensure NO delay in authorization process.**

- 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
- Provider is registered with the Lemtrada® REMS program
- Patient has completed a trial and has failed at least **TWO (2)** of the following agents: (**check ALL tried**)

<input type="checkbox"/> Aubagio® (teriflunomide)	<input type="checkbox"/> Avonex® (IFN beta-1b)	<input type="checkbox"/> Betaseron® (IFN beta-1a)
<input type="checkbox"/> Copaxone® (glatiramer acetate)	<input type="checkbox"/> Extavia® (IFN beta-1a)	<input type="checkbox"/> Gilenya® (fingolimod)
<input type="checkbox"/> Plegridy® (pegylated-IFN beta-1a)	<input type="checkbox"/> Rebif® (IFN beta-1a)	<input type="checkbox"/> Tecfidera® (dimethyl fumarate)
<input type="checkbox"/> Tysabri® (natalizumab)		

**For Infusions Year 3 and beyond, check below all of the following:**

- Prescriber is a Neurologist
- Patient has a confirmed diagnosis of relapsing-remitting MS
- Patient's last Lemtrada® infusion was at least 12 months ago
- Patient has had at least one medically documented clinical relapse within 12 months with disease progression (**chart notes must be submitted**)
- The provider is registered with the Lemtrada® REMS program

(signature on next page)

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

Physician's office

**OR**

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 #: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_

\*Approved by Pharmacy and Therapeutics Committee: 3/19/2015

REVISED/UPDATED: 6/24/2015; 12/8/2015; 12/28/2015; 1/29/2016; 8/10/2016; 9/22/2016; 12/11/2016; 5/30/2017; 6/8/2017; 9/15/2017; 10/4/2017