

OPTIMA HEALTH PLAN

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 1-844-202-5034. 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: **Ocrevus™ (ocrelizumab) Injection (J-3590) (Medical) (Non-Preferred)**

DRUG INFORMATION: Complete all information below. Authorization process will be delayed if incomplete.

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: All boxes that apply **MUST** be checked to qualify. Incomplete information will delay the authorization process.

Please check all below for Primary Progressive MS indication. If NOT checked, authorization process will be delayed.

- Prescriber is a Neurologist
- Patient has a confirmed diagnosis of Primary Progressive MS

Please check all below for Relapsing-Remitting MS indication. If NOT checked, authorization process will be delayed.

- 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):*

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

(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 Number: _____

DEA OR NPI #: _____

*Approved by the Pharmacy and Therapeutic Committee: 5/18/2017

UPDATED: 5/30/2017; 6/30/2017; 9/16/2017; 10/4/2017;