# 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: Ocrevus™** (ocrelizumab) **Injection (J-2350/C9494) (Medical) (Non-Preferred)**

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

**Drug Form/Strength:** _____

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

**Diagnosis:** _____ **ICD Code:** _____

**RECOMMENDED DOSAGE AND ADMINISTRATION:**

**INITIAL DOSE: 300 mg intravenous infusion, followed 2 weeks later by a 2nd 300 mg intravenous infusion**
**SUBSEQUENT DOSES: single 600 mg intravenous infusion every 6 months**

**Medical notes MUST be submitted with this request to support each line checked.**

**CLINICAL CRITERIA:** **All** boxes that apply **MUST** be checked to qualify. Incomplete information **or** any medical notes **not** attached with this form request will delay the authorization process.

**Please check all below for Primary Progressive Multiple Sclerosis (MS) indication.** If boxes are **NOT** checked, authorization could be delayed. Medical notes **MUST** be attached to this request**.**

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

**Please check all below for Relapsing-Remitting MS indication.** If boxes are **NOT** checked, authorization will be delayed. Medical notes **MUST** be attached to this request.

- ❑ 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):**

| | | |
|---|---|---|
| ❑ Aubagio® (teriflunomide) | ❑ Betaseron® (IFN beta-1a) | ❑ Extavia® (IFN beta-1a) |
| ❑ Avonex® (IFN beta-1b) | ❑ Copaxone® (glatiramer acetate) | ❑ Gilenya® (fingolimod) |
| ❑ Lemtrada® (alemtuzumab) **(Requires prior authorization)** | ❑ Rebif® (IFN beta-1a) | ❑ Plegridy® (pegylated-IFN beta-1a) |
| ❑ Tecfidera® (dimethyl fumarate) | ❑ Tysabri® (natalizumab) **(Requires prior authorization)** | |

**(Continued on next page; signature page must be included with request)**

**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~~; ~~8/6/2017~~; ~~12/16/2017~~;**10/1/2018**