# 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:** **Tysabri®** (natalizumab) **(J-2323)** ***(Medical)***

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

**Drug Form/Strength/Month:** _____

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

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

***CLINICAL CRITERIA: Check all boxes below that apply for specific diagnosis. If NOT checked or incomplete, authorization could be delayed.***

### *Check all below for MS indication*:

- ❑ 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 is registered with the Tysabri® risk management program known as TOUCH™
- ❑ Patient has completed a trial and has failed at least **ONE (1)** of the following agents:

***(Check all tried)***

- ❑ Aubagio® (teriflunomide)
- ❑ Avonex® (IFN beta-1b)
- ❑ Betaseron® (IFN beta-1a)
- ❑ Copaxone® (glatiramer acetate)
- ❑ Extavia® (IFN beta-1a)
- ❑ Gilenya® (fingolimod)
- ❑ Plegridy® (peginterferon beta-1a)
- ❑ Rebif® (IFN beta-1a)
- ❑ Tecfidera® (dimethyl fumarate)

**OR**

- ❑ Patient's current or potential disease progression warrants the use of Tysabri®

### *Check all below for Crohn's indication*:

- ❑ Prescriber is a Gastroenterologist
- ❑ Patient has moderate to severe active Crohn's disease with evidence of inflammation
- ❑ Patient is registered with the Tysabri® risk management program known as CD TOUCH™
- ❑ Patient has had failure of conventional therapies: Budesonide or high dose steroids (prednisone 40-60mg)

- ❑ ***Trial and Failure of all***:
  - ❑ Remicade®

**AND**

  - ❑ Humira®

***(signature on next page)***

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

- ❑ **Location/site of drug administration:** _____

  **NPI or DEA # of administering location**: _____

  **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 Pharmacy and Therapeutics Committee**: 3/20/2008
**REVISED/UPDATED:** ~~7/16/2009; 6/3/2011; 9/9/2011; 5/2/2012~~; ~~7/2/2012; 9/10/2012; 2/21/2013; 6/30/13; 5/8/2014; 8/18/2014; 10/31/2014; 4/3/2015; 5/23/2015; 12/30/2015; 1/29/2016; 7/18/2016; 9/22/2016; 12/11/2016; 7/24/2017; 9/18/2017;~~ **7/10/2018**