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; **(Pharmacy) 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (Check applicable drug below)

❑ **glatiramer acetate**	❑ **Glatopa®** (glatiramer acetate)

DRUG INFORMATION: Complete information below or authorization will be delayed if incomplete.

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

- ❑ Patient must have a contraindication to Brand Copaxone®. Must submit clinical chart notes or a completed Med Watch form documenting the experienced treatment failure with Brand Copaxone®.

Medication being provided by Specialty Pharmacy - PropriumRx

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~~; ~~12/11/2016~~; ~~8/3/2017~~; ~~9/29/2017~~ **5/15/2019**;