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 1-844-723-2094. 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. Authorization process will be delayed if incomplete.

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 boxes that apply must be checked. Incomplete information will delay the authorization process.

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. 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
- ❑ The 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):***

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

(continued on next page)

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

Medication being provided by (check applicable box below):

❑ **Physician's office**

OR

❑ **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 #: _____

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;~~ **7/24/2017**;