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; fax to 1-800-750-9692. 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.***

Relapsing Remitting Multiple Sclerosis (MS) - *(Non-Preferred)*

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Name/Form/Strength: _____

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

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

To qualify, chart notes must be submitted with form.

Drug Requested*:** ***(Check applicable box below)

❑ **Aubagio**® (teriflunomide)	❑ **Rebif**® (interferon beta-1a)
❑ **Extavia**® (interferon beta-1b)	❑ **Zinbryta**™ (daclizumab)
❑ **Plegridy**® (PegInterferon beta-1a)	

CLINICAL CRITERIA: ALL boxes must be checked to qualify. Authorization process will be delayed if incomplete.

❑ Physician is a Neurologist

AND

❑ Patient must have documentation of trial and failure with **TWO (2)** of the following: ***(Check each that has been tried)*:**

❑ Avonex®	❑ Copaxone®
❑ Betaseron®	❑ Tecfidera®

==========

❑ **Gilenya**® (fingolimod) ***(Non-Preferred)***

CLINICAL CRITERIA: ALL boxes must be checked to qualify. Authorization process will be delayed if incomplete.

❑ Physician is a Neurologist

AND

(continued on next page)

- ❑ Patient must have documentation of trial and failure with **ONE (1)** of the following: ***(Check each that has been tried)*:**

❑ Avonex®	❑ Copaxone®
❑ Betaseron®	❑ Tecfidera®

Medication being provided by a 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**: ~~4/10/2007~~; 8/20/2015
UPDATED: ~~6/3/2011; 8/15/2011, 5/17/2012; 7/3/2012; 4/7/2014; 5/8/2014; 6/2/2014; 8/8/2014; **10/30/2014**; 3/19/2015; 5/27/2015; 10/26/2015~~; ~~12/22/2015; 6/28/2016; 7/21/2016; 8/22/2016; 9/22/2016; 12/11/2016; 5/29/2017; 6/28/2017;~~ **8/5/2017**