

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 1-844-723-2094.** 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: Ocrevus™ (ocrelizumab) Injection (J-2350/C9494) (Medical) (Non-Preferred)

DRUG INFORMATION: Complete all information below or authorization 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 medical notes **not** attached with this request will delay the authorization.

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

<input type="checkbox"/> Aubagio® (teriflunomide)	<input type="checkbox"/> Betaseron® (IFN beta-1a)	<input type="checkbox"/> Extavia® (IFN beta-1a)
<input type="checkbox"/> Avonex® (IFN beta-1b)	<input type="checkbox"/> Copaxone® (glatiramer acetate)	<input type="checkbox"/> Gilenya® (fingolimod)
<input type="checkbox"/> Lemtrada® (alemtuzumab) (Requires prior authorization)	<input type="checkbox"/> Rebif® (IFN beta-1a)	<input type="checkbox"/> Plegridy® (pegylated-IFN beta-1a)
<input type="checkbox"/> Tecfidera® (dimethyl fumarate)	<input type="checkbox"/> 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 - 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: 5/18/2017

UPDATED: 5/30/2017; 6/30/2017; 8/6/2017; 12/12/2017; 9/28/2018.