

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

DRUG INFORMATION: Complete information below. If incomplete, 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 process will 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):

- 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 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**