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 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization will be delayed**.

For Medicare Members: Medicare Coverage for our members (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Radicava® (edaravone) IV (Codes C9399/J3490) (Medical)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

- ❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval Length – 6 months (no more than 86 doses over 180 days)

- ❑ **Prescriber is a Neurologist**
  - ❑ Member is ≥ 18 years of age
  - ❑ Member has diagnosis of "definite" or "probable" amyotrophic lateral sclerosis (ALS) per the EL Escorial

AND

  - ❑ Functionality retained most activities of daily living **(defined as scores of 2 points or better on each individual item of the ALS Functional Rating Scale-Revised (ALSFRS-R)) (must be submitted)**

AND

  - ❑ Normal respiratory function confirming Member has a % forced vital capacity (%FVC) ≥ 80% at the start of treatment **(medical records must be attached)**
  - ❑ Disease duration of two (2) years or less **(progress notes must document date)**

AND

Radicava® is considered an **Exclusion for score of 3 or less on ALSFRS-R items for dyspnea, orthopnea, or respiratory insufficiency;** history of spinal surgery after onset of ALS.

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Reauthorization Approval Length – 6 months (no more than 86 doses over 180 days). All criteria must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Functionality retained most activities of daily living (defined as score from baseline did not decrease on each individual item of the ALS Functional Rating Scale-Revised (ALSFRS-R)

AND

- ❑ Normal respiratory function confirming the Member has a % forced vital capacity (%FVC) ≥ 80%.

Medication being provided by (check applicable box below):

- ❑ **Location/site of drug administration:** _____

NPI or DEA # of administering location: _____

OR

- ❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Optima Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Optima's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****

Member 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**: 8/17/2017
REVISED/UPDATED: ~~9/28/2017~~; ~~12/30/2017~~; ~~5/24/2018~~; **(Reformatted)** ~~3/19/2019~~; ~~7/8/2019~~; **9/20/2019**;