ATRIO HEALTH PLANS

Multiple Sclerosis Drugs

Ocrevus (ocrelizumab) J2350, Copaxone (Glatiramer acetate) J1595, Zenapax (daclizumab) J7513, Briumvi (ublituximab) J2329, Tyruko (natalizumab-sztn) Q5134, are Non-preferred. The preferred products are Part D alternatives including Aubagio and generic glatiramer (See Part D Formulary, no PA required for most preferred Part D alts).

Prior Authorization Step Therapy Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ **New Start or Initial Request: (Clinical documentation required for all requests)**

☐ **Tyruko (Q5134)**

- ☐ Diagnosis of relapsing multiple sclerosis (RMS) (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease); AND
  - ☐ Patient enrolled in and meeting all conditions of the MS Touch Prescribing Program; OR
- ☐ Diagnosis of moderate to severe Crohn's disease (CD) and is using Tysabri/Tyruko for induction and maintenance of clinical response and remission; AND
  - ☐ Individual has had an inadequate response to or is unable to tolerate conventional Crohn's disease therapies and TNF-α inhibitors; AND
  - ☐ Patient enrolled in and meeting all conditions of the CD Touch Prescribing Program; AND
  - ☐ Patient has had a John Cuningham virus (JCV) antibody test and the results as well as risks and benefits have been discussed and understood.

☐ **All Other Drugs - Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____
_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____
_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Multiple Sclerosis Drugs PA

Drug Name(s):

OCREVUS	**OCRELIZUMAB**
COPAXONE	**GLATIRAMER ACETATE**
ZENAPAX	**DACLIZUMAB**
BRIUMVI	**UBLITUXIMAB**
TYRUKO	**NATALIZUMAB-SZTN**

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approvals will be for 12 months

FDA Indications:

Ocrevus

- Multiple sclerosis, Relapsing forms
- Primary progressive multiple sclerosis

Copaxone, Briumvi

- Multiple sclerosis, Relapsing forms

Tyruko

- Crohn's disease (Moderate to Severe), Previous inadequate response to, or unable to tolerate, conventional therapies and tumor necrosis factor-alpha inhibitors
- Multiple sclerosis, Relapsing forms, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; monotherapy

Zenapax

- The worldwide marketing and distribution of Zinbryta(R) (daclizumab) was voluntarily discontinued on March 2, 2018 due to safety concerns

Off-Label Uses:

N/A

Age Restrictions:

Safety and effectiveness of ocrelizumab have not been established in pediatric patients

Other Clinical Considerations:

Ocrevus

- Active hepatitis B virus infection

Tyruko

- History of or active progressive multifocal leukoencephalopathy

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/9E37E3/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/5D1C03/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=ocrelizumab&UserSearchTerm=ocrelizumab&SearchFilter=filterNone&navitem=searchGlobal#

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