PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Zinbryta (daclizumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Zinbryta 150 mg/mL injection

Start date (or date of next dose): _____
Dose:_____ **Dose Frequency**:_____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of relapsing-remitting multiple sclerosis (RRMS), secondary-progressive multiple sclerosis (SPMS), or progressive-relapsing multiple sclerosis (PRMS).
2. Prescriber is board-certified neurologist or multiple sclerosis physician specialist with experience prescribing MS therapy.
3. Patient will not be using in combination with another disease-modifying agent for MS.
4. Must try and fail two of the preferred agents including: Avonex, Glatopa, Tecfidera, or Rebif. Failure or inadequate response is defined below.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ RRMS ☐ SPMS ☐ PRMS
☐ *Other – the patient's condition is:* _____

B. Is the prescriber a neurologist?

☐ Yes ☐ No

C. Will patient be using in combination with another disease-modifying agent for MS?

☐ Yes, *rationale:* _____
☐ No

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2016
Last reviewed 05/2018

D. What other treatments has the patient tried?

☐ Avonex	☐ **Discontinued, Reason:**_____	**Duration**:_____	
☐ Rebif	☐ **Discontinued, Reason:**_____	**Duration**:_____	
☐ Tecfidera	☐ **Discontinued, Reason:**_____	**Duration**:_____	
☐ Copaxone	☐ **Discontinued, Reason:**_____	**Duration**:_____	
☐ Glatopa	☐ **Discontinued, Reason:**_____	**Duration**:_____	

☐ Other, please list: _____

E. Inadequate response due to (2 of the 3 must be met):

☐ Increase in frequency (at least one clinical relapses within the past 12 months), severity and/or sequelae of relapses

☐ Changes in MRI: continues to have CNS lesion progression as measured by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions and/or T1 hypointense lesions)

☐ Increase in disability progression: Sustained worsening of EDSS score, routine neurological observation, mobility, or ability to perform activities of daily living

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