AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Daclizumab (Zinbryta)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for daclizumab (Zinbryta). Payment will be considered under the following conditions:

1) Patient has a diagnosis of a relapsing form of multiple sclerosis (MS); and

2) Patient is 18 years of age or older; and

3) Patient has documentation of previous trials and therapy failures with two or more drugs indicated for the treatment of MS; and

4) Patient does not have pre-existing hepatic disease or hepatic impairment (including hepatitis B or C); and

5) Baseline transaminases (ALT, AST) and bilirubin levels are obtained; and

6) Patient does not have an ALT or AST at least two times the upper limit of normal (ULN); and

7) Patient does not have a history of autoimmune hepatitis or other autoimmune condition involving the liver; and

8) Patient has been screened for TB and treated for TB if positive; and

9) Daclizumab will be used as monotherapy; and

10) Daclizumab will be dosed as 150 mg once monthly; and

11) Prescriber, patient, and pharmacy are enrolled in the Zinbryta REMS program.

12) The 72-hour emergency supply rule does not apply to daclizumab.

13) Lost or stolen medication replacement requests will not be authorized. If criteria for coverage are met, an initial authorization will be given for 12 months. Additional authorizations will be considered when documentation of a positive clinical response to daclizumab therapy is provided.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult **www.iowamedicaidpdl.com/pa_criteria.**

Non-Preferred

☐ Zinbryta

Strength	Dosage instructions	Quantity	Days supply
Diagnosis:			

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Document two or more previous treatment failures:

Trial 1 — Drug name and dose: _____ Trial dates: _____

Reason for failure: _____

Trial 2 — Drug name and dose:_____ Trial dates: _____

Reason for failure: _____

Trial 3 — Drug name and dose:_____ Trial dates: _____

Reason for failure: _____

Does patient have pre-existing hepatic disease or hepatic impairment? ☐ Yes ☐ No

Have baseline transaminases (ALT, AST) been obtained? ☐ Yes (attach results) ☐ No

Does patient have ALT or AST at least 2 times the upper limit of normal? ☐ Yes ☐ No

Does patient have a history of autoimmune hepatitis or other autoimmune condition involving the liver? ☐ Yes ☐ No

Has patient been screened for TB and treated for TB if positive?

☐ Yes, provide result and treatment if positive:
☐ No

Will daclizumab be used as monotherapy? ☐ Yes ☐ No

Prescriber, patient, and pharmacy are enrolled in the Zinbryta REMS Program: ☐ Yes ☐ No

Renewal requests:
Provide documentation of positive clinical response to daclizumab therapy:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish that the member continues to be eligible for Medicaid by inspection of the member's Medicaid eligibility card and/or contacting the county Department of Human Services.

Check **www.amerihealthcaritasia.com/provider** to confirm your version of this form.