OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Zinbryta® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Multiple sclerosis (MS)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have a diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses)? ❑ **Yes** ❑ **No**

Select if the patient has history of trial and failure, intolerance, or contraindication to the following:

- ❑ Aubagio (teriflunomide)
- ❑ Avonex (interferon beta-1a)
- ❑ Betaseron (interferon beta-1b)
- ❑ Copaxone (glatiramer acetate)
- ❑ Extavia (interferon beta-1b)
- ❑ Generic glatiramer acetate
- ❑ Gilenya (fingolimod)
- ❑ Glatopa (glatiramer acetate)
- ❑ Lemtrada (alemtuzumab)
- ❑ Ocrevus (ocrelizumab)
- ❑ Plegridy (peginterferon beta-1a)
- ❑ Rebif (interferon beta-1a)
- ❑ Tecfidera (dimethyl fumarate)
- ❑ Tysabri (natalizumab)

Will the patient be receiving daclizumab in combination with another disease-modifying agent for MS? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to Zinbryta therapy? ❑ **Yes** ❑ **No**

Will the patient be receiving daclizumab in combination with another disease-modifying agent for MS? ❑ **Yes** ❑ **No**

Quantity Limit:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading-dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____

❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.