



Request for Prior Authorization
DACLIZUMAB (ZINBRYTA)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, and 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 2 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.

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 & dose: _____ Trial dates: _____

Reason for failure: _____

Trial 2: Drug name & dose: _____ Trial dates: _____

Reason for failure: _____

Trial 3: Drug name & 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.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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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 by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.