Prior Authorization Request Form for
ofatumumab injection **(Kesimpta)**

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question		
1. **Is the patient 18 years of age or older?**	☐ Yes Proceed to Question **2**	☐ No **STOP** **Coverage not approved**
2. **Is the requested medication prescribed by or in consultation with a neurologist?**	☐ Yes Proceed to Question **3**	☐ No **STOP** **Coverage not approved**
3. **For which indication or diagnosis is the requested medication being prescribed?**	☐ Relapsing forms of MS - Proceed to Question **4** ☐ Other - **STOP Coverage not approved**	
4. **Is the patient currently using another disease-modifying therapy (for example, interferon, glatiramer, Tecfidera, Vumerity, Aubagio, Gilenya, Mayzent, Zeposia, Mavenclad, etc.)**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **5**
5. **Does the patient have an active hepatitis B virus infection?**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **6**
6. **Has the patient failed a course of Ocrevus?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________________ ______________
Prescriber Signature Date

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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: