Lemtrada

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Exception Criteria:

A. Is the product being requested for the treatment of a relapsing form of multiple sclerosis?
❑Yes ❑No, *skip to Clinical Criteria Questions*

B. *The preferred product for your patient's health plan is Ocrevus and Tysabri.*
Can the patient's treatment be switched to the preferred product?
❑Yes, *Please obtain Form for preferred product and submit for corresponding PA* ❑No

C. Is this request for continuation of therapy with the requested product?
❑ Yes ❑ No, *skip to letter E in this section*

D. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'?
❑ Yes, *skip to Site of Service Questions* ❑ No

E. Does the patient have documented inadequate response(s) and/or intolerable adverse event(s) to treatment with both of the preferred products (Ocrevus and Tysabri)? **Action Required:** ***If 'Yes', attach supporting chart note(s).***
❑ Yes, *skip to Site of Service Questions* ❑ No

F. Does the patient have documented contraindications to both of the preferred products (Ocrevus and Tysabri)?
Action Required: ***If 'Yes', attach supporting chart note(s).***
❑ Yes ❑ No

Site of Service Questions:

A. Indicate the site of service requested:
❑ On Campus Outpatient Hospital
❑ Off Campus Outpatient Hospital
❑ Home based setting, *skip to Criteria Questions*
❑ Community office, *skip to Criteria Questions*
❑ Ambulatory infusion site, *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
❑ Yes, *skip to Clinical Criteria Questions*
❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the diagnosis?
   ❑ Relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse)
   ❑ Primary progressive multiple sclerosis (PPMS)
   ❑ Other _____
2. What is the ICD-10 code? _____

Complete the following questions if patient has a relapsing form of multiple sclerosis.

3. How many courses of the requested medication has the patient previously received?
   ❑ No previous courses (0 doses)
   ❑ One course or more (5 doses or more) *Skip to #6*
4. Has the patient had an inadequate response to **two or more** drugs indicated for multiple sclerosis? ❑ Yes ❑ No
5. Is the patient taking the requested medication with any other disease modifying multiple sclerosis (MS) agent? (Note: Ampyra and Nuedexta are not disease modifying.) ❑ Yes ❑ No *No further questions.*
6. Has the patient received the last dose of the previous course of the requested medication at least 12 months prior to the planned date of the first dose of the subsequent treatment course of the requested medication? ❑ Yes ❑ No
7. Is the patient taking the requested medication with any other disease modifying multiple sclerosis (MS) agent? (Note: Ampyra and Nuedexta are not disease modifying.) ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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