OCREVUS™ (OCRELIZUMAB)
Preauthorization Request
(Preauthorization is not a guarantee of payment)

SECTION I – General Information	
Today's Date: / /	☐ New request
Fax completed form to:**1-866-805-4150 toll free**	☐ Re-Authorization

Level of Urgency:

Standard Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

Expedited Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For Expedited Request, Please Explain:

SECTION II – Member Information		
Patients Name:	Member ID:	**Patient Information**: DOB:__/__/__ Sex: Age: Weight: ☐ lbs. ☐ Kg Will the patient self-administer the requested medication? ☐ Yes ☐ No
Patients Address:	Is CBC primary payer: ☐ Yes ☐ No	

Plan Type:

☐ PPO ☐ POS ☐ KHPC ☐ CHIP (aka Capital Cares 4Kids)

☐ Traditional ☐ Comprehensive ☐ Special Care ☐ Other* _____

NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at https://www.covermymeds.com/main or via phone at 1-866-260-0452.

SECTION III – Provider Information Required	
Requesting Provider Name: **Address**:	**Requesting Provider CBC #**_____ **NPI #** _____

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Telephone #:	Secure Fax #:
Office Contact Name:	Office Contact Telephone #:
Is the Rendering/Servicing provider different? ☐ No ☐ Yes – Complete rendering provider information below.	
Rendering Provider Name: **Address**: **Telephone:**	**Rendering Provider CBC #**_____ **NPI #** _____
Site of Service: ☐ MD Office ☐ Home Health ☐ Non-hospital affiliated, outpatient infusion center ☐ Hospital affiliated, outpatient infusion center ☐ Other: Specify _____ **Please refer to MP 3.016 for Site of Service requirements.*	**Check all that apply and include all applicable documentation:** ☐ There are contraindications to a less intensive site of care. ☐ A less intensive site of care is not appropriate for the patient's condition. ☐ Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently. ☐ Less intensive site of care is not available. **Please include all applicable documentation.*

SECTION IV – Preauthorization Requirements and Clinical Criteria

Is the prescriber a specialist in the area of the patient's diagnosis or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes Specialty: _____ ☐ No

☐ New to therapy ☐ Continuing therapy*: Initial start __/__/__ ☐ Reinitiating therapy: Last treatment __/__/__ *Please include documentation for changes in dose.	**Route of Administration:** ☐ Intravenous (IV) ☐ Injection (Sub Q or IM) ☐ Oral (PO) or Enteral ☐ Other: Specify _____
HCPC Code(s):	**Diagnosis Code(s)**:
Medication requested:	**Indication:**

Does the patient have late stage metastatic disease? ☐ Yes ☐ No

For patients with late stage metastatic disease (Stage IV), please refer to MP 2.373 Step Therapy Treatment in Cancer, Including Treatments for Stage Four, Advanced Metastatic Cancer and Severe Related Health Conditions for additional guidance.

Type of drug requested: ☐ Brand name ☐ Generic ☐ Biosimilar ☐ Other: Specify _____

Initial start date of therapy: __/__/__	Anticipated date of **next administration:** __/__/__

Dosing period for request: Start Date: __/__/__ End Date __/__/__	**Dosing Information:** Dose: Strength: Frequency: Quantity requested per month:

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<u>Attach documentation demonstrating the medical necessity of the requested drug.</u> Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.)
Has the patient had **medical testing** completed for use of this drug? (labs, imaging) ☐ Yes ☐ No Results:_____
Is drug being requested for an "**off label" indication**? ☐ Yes ☐ No If yes, please see Medical Policy 2.103 and include any applicable documentation.
Please list any previous medications that were **<u>tried and failed</u>**. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach documentation. Drug(s) and strength: Documentation of failure:
☐ **Ocrevus™ (ocrelizumab)**

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Capital

Patient is 18 years or older □ Yes □ No

Patient has been screened for the presence of Hepatitis B virus (HBV) prior to initiating treatment AND does not have active disease □ Yes □ No

Patient has baseline serum immunoglobulins assessed □ Yes □ No

Patient will not receive live or live-attenuated vaccines while on therapy or within 4 weeks prior to initiation of treatment;□ Yes □ No

Patient does not have an active infection □ Yes □ No

Multiple Sclerosis

Patient must have a confirmed diagnosis* of multiple sclerosis (MS) as documented by laboratory report (i.e., MRI);

Will be used as single agent therapy □ Yes □ No

Patient has a diagnosis of a relapsing form of MS [i.e., relapsing-remitting MS (RRMS)*, active secondary progressive disease (SPMS)**, or clinically isolated syndrome (CIS) □ Yes □ No

Patient has a diagnosis**** of primary progressive MS (PPMS) □ Yes □ No

If yes;

Patient is less than 65 years□ Yes □ No

Patient has an expanded disability status scale (EDSS) score of ≤ 6.5□ Yes □ No

Renewal Criteria (complete in addition to above)

Patient has not received a dose of ocrelizumab within the past 5 months□ Yes □ No

Patient has absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: severe infusion reactions, severe infections, progressive multifocal leukoencephalopathy' malignancy, hypogammaglobulinemia, immune-mediated colitis etc.□ Yes □ No

Does continuous monitoring of patients response to therapy indicate:

- Beneficial response [manifestations of MS disease activity include, but are not limited to, an increase in annualized relapse rate (ARR), development of new/worsening T2 hyperintensities or enhancing lesions on brain/spinal MRI, and progression of sustained impairment as evidenced by expanded disability status scale (EDSS), timed 25-foot walk (T25-FW), 9-hole peg test (9-HPT)] □ Yes □ No ; **OR**
- Inadequate response, in those who have been adherent and receiving therapy for sufficient time to realize the full treatment effect, is defined as ≥ 1 relapse, ≥ 2 unequivocally new MRI-detected lesions, or increased disability on examination over a one-year period □ Yes □ No

For PPMS:

Does the patient continue to be ambulatory, defined as an EDSS score of < 7.5? □ Yes □ No

Please use a separate form for each drug. To fill out form type or write using blue or black ink **Please fax this form to: 1-866-805-4150** Telephone: 1-800-471-2242	**CONFIDENTIALITY NOTICE**: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received

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Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.	this communication in error, please notify the sender immediately by telephone at 1-800-471-2242. Thank you for your cooperation.

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