aetna®

Ocrevus (Ocrelizumab) Medication Precertification Request

(All fields must be completed and return all pages for precertification review)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment, start date: ____/____/____ ☐ Continuation of therapy, date of last treatment: ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Neurologist** ☐ **Primary Care** **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Ocrevus: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD Code: _____ ☐ **Other ICD Code**: _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For *All* Requests (clinical documentation required for all requests)

Please indicate the type of multiple sclerosis the patient has been diagnosed with:
☐ Relapsing-remitting (RRMS) ☐ Secondary-progressive MS (SPMS) ☐ Primary-progressive MS (PPMS) ☐ Progressive-relapsing MS (PRMS)

☐ Yes ☐ No Will the drug requested be used as monotherapy for treatment of multiple sclerosis (with exception of Ampyra)?
☐ Yes ☐ No Does the patient have an active hepatitis B virus infection?
☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Is the patient medically unstable for infusions at alternate levels of care?
☐ Yes ☐ No Does the patient have a history of any cardiopulmonary conditions?
→ Please provide the description of the condition: _____
☐ Yes ☐ No Does this condition cause an increased risk of severe adverse reactions?
☐ Yes ☐ No Does the patient have documentation of unstable vascular access?
☐ Yes ☐ No Does the patient have physical or cognitive impairments such that home infusion would present an unnecessary health risk?
→ Please explain: _____
☐ Yes ☐ No Is there clinical evidence that the patient has an inability to safely tolerate intravenous volume load (including from unstable renal function)?
→ ☐ Yes ☐ No Is the inability to tolerate intravenous volume load due to unstable renal function?
→ Please document the following: ☐ GFR:_____ mL/min/1.73m^2 Date Collected: ____/____/____
☐ BUN:_____ mg/dL Date Collected: ____/____/____
☐ Creatinine:_____ mg/dL Date Collected: ____/____/____

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For *relapsing multiple sclerosis* requests:

How many of the following medications have been ineffective, not tolerated or contraindicated:

Aubagio, Avonex, Betaseron, Gilenya, Glatopa 20 mg or Copaxone 40 mg, Lemtrada, Plegridy, Rebif, Tecfidera? ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

Please indicate the ***first*** medication that has been ineffective, not tolerated or contraindicated:

☐ Aubagio ☐ Avonex ☐ Betaseron ☐ Gilenya ☐ Glatopa 20 mg or Copaxone 40 mg ☐ Lemtrada ☐ Plegridy
☐ Rebif ☐ Tecfidera

Please identify if treatment with medication was ineffective, not tolerated or contraindicated:

☐ Ineffective
→ Please indicate which of the following describe the evidence of treatment failure:
- ☐ The patient has increasing relapses (defined as two or more relapses in a year, or one severe relapse associated with either poor recovery or MRI lesion progression)
- ☐ The patient has lesion progression by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions or T1 hypointense lesions)
- ☐ The patient has worsening disability (sustained worsening of Expanded Disability Status Scale (EDSS) score or neurological examination findings)
- ☐ Other (please explain): _____

☐ Not tolerated
→ ☐ Yes ☐ No Have the intolerable side effects persisted despite optimized management strategies?

☐ Contraindicated

Please indicate the ***second*** medication that has been ineffective, not tolerated or contraindicated:

☐ Aubagio ☐ Avonex ☐ Betaseron ☐ Gilenya ☐ Glatopa 20 mg or Copaxone 40 mg ☐ Lemtrada ☐ Plegridy
☐ Rebif ☐ Tecfidera

Please identify if treatment with this medication was ineffective, not tolerated or contraindicated:

☐ Ineffective
→ Please indicate which of the following describe the evidence of treatment failure:
- ☐ The patient has increasing relapses (defined as two or more relapses in a year, or one severe relapse associated with either poor recovery or MRI lesion progression)
- ☐ The patient has lesion progression by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions or T1 hypointense lesions)
- ☐ The patient has worsening disability (sustained worsening of Expanded Disability Status Scale (EDSS) score or neurological examination findings)
- ☐ Other (please explain): _____

☐ Not tolerated
→ ☐ Yes ☐ No Have the intolerable side effects persisted despite optimized management strategies?

☐ Contraindicated

Please indicate the ***third*** medication that has been ineffective, not tolerated or contraindicated:

☐ Aubagio ☐ Avonex ☐ Betaseron ☐ Gilenya ☐ Glatopa 20 mg or Copaxone 40 mg ☐ Lemtrada ☐ Plegridy
☐ Rebif ☐ Tecfidera

Please identify if treatment with this medication was ineffective, not tolerated or contraindicated:

☐ Ineffective
→ Please indicate which of the following describe the evidence of treatment failure:
- ☐ The patient has increasing relapses (defined as two or more relapses in a year, or one severe relapse associated with either poor recovery or MRI lesion progression)
- ☐ The patient has lesion progression by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions or T1 hypointense lesions)
- ☐ The patient has worsening disability (sustained worsening of Expanded Disability Status Scale (EDSS) score or neurological examination findings)
- ☐ Other (please explain): _____

☐ Not tolerated
→ ☐ Yes ☐ No Have the intolerable side effects persisted despite optimized management strategies?

☐ Contraindicated

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For *primary progressive MS (PPMS) requests:*

Please indicate the length of disease progression (retrospectively or prospectively determined): ☐ Less than 1 year ☐ 1 year or greater

☐ Yes ☐ No Does the patient has one or more brain T2 lesions in at least one area characteristic for multiple sclerosis (periventricular, juxacortical, or infratentorial)?

☐ Yes ☐ No Does the patient have two or more T2 lesions in the spinal cord?

☐ Yes ☐ No Does the patient have positive CSF (isoelectric focusing evidence of oligoclonal IgG bands or increased IgG index, or both)?

For *continuation* requests:

☐ Yes ☐ No Has the patient received Ocrevus within the past 6 months?

→ ☐ Yes ☐ No Does the patient have a documented severe and/or potentially life threatening adverse event that occurred during or following the previous infusion?

→ ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the home or office setting?

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Ocrevus? (Sampling of Ocrevus does not guarantee coverage under the provision of the pharmacy benefit)

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.