



MEDICARE FORM

Ocrevus® (ocrelizumab)

Medication Precertification Request

Page 1 of 2

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

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

For other lines of business:

Please use other form.

Note: Ocrevus is non-preferred for relapsing forms of multiple sclerosis for MAPD plans. The preferred product is Kesimpta.

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 #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____

Medicare: Yes No If yes, provide ID #: _____ Medicaid: Yes No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: (Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> 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: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____
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E. PRODUCT INFORMATION

Request is for Ocrevus (ocrelizumab) 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):

Note: Ocrevus is non-preferred for relapsing forms of multiple sclerosis for MAPD plans. The preferred product is Kesimpta.

Yes No Has the patient had prior therapy with Ocrevus (ocrelizumab) within the last 365 days?

Yes No Has the patient had a trial, intolerance, or contraindication to Kesimpta (ofatumumab)?

Please explain if there are any medical reason(s) that the patient cannot use Kesimpta (ofatumumab) when indicated for the patient's diagnosis

Yes No Is this infusion request in an outpatient hospital setting?

Yes No Is this request to continue previously established treatment with the requested medication?

Please explain: This is a new therapy request (patient has not received requested medication in the last 6 months)

Yes No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., 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?

Yes No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Yes No 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?

→ Please provide a description of the behavioral issue or impairment: _____

Yes No 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?

→ Please provide a description of the condition:

Cardiovascular: _____

Respiratory: _____

Renal: _____

Please indicate the type of multiple sclerosis the patient has been diagnosed with:

Relapsing form of multiple sclerosis (relapsing-remitting and secondary progressive disease for those who continue to experience relapses)

Primary-progressive MS (PPMS) Clinically isolated syndrome Other (please explain): _____

Yes No Is the patient taking the requested medication with any other medication used for the treatment of multiple sclerosis other than Ampyra?

For Continuation requests (Clinical documentation required for all requests):

Yes No Is the patient experiencing disease stability or improvement while receiving the requested medication?

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.