PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Ocrevus (ocrelizumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the patient a new start to Ocrevus?

☐ Yes ☐ No - please provide Ocrevus start date

Q2. What type of multiple sclerosis does the patient have?

☐ Primary progressive multiple sclerosis (PPMS)
☐ Relapsing-remitting multiple sclerosis (RRMS)
☐ Other (please specify)
☐ Not applicable - patient does not have multiple sclerosis

Q3. Please provide ICD code(s) for diagnosis.

Q4. Is the prescriber a Neurologist?

☐ Yes ☐ No

Q5. Does the patient have active Hepatitis B infection?

☐ Yes ☐ No

Q6. For PPMS, has the patient had disease progression over at least a 12 month time period?

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☐ Yes ☐ No

Q7. For PPMS, does the patient have any of the following? Please select all that apply:

☐ Evidence for dissemination in space (DIS) in the brain based on one or more T2 lesions with at least one that is characteristic for MS (periventricular, juxtacortical, or infratentorial)

☐ Evidence for DIS in the spinal cord based on at least two T2 lesions in the cord

☐ Isoelectric focusing evidence of oligoclonal bands and/or elevated IgG index in the cerebrospinal fluid (CSF)

☐ None of the above

Q8. For RRMS, does the patient have failure of an adequate trial of any of the following disease modifying therapies? Please select all that apply.

☐ Avonex, Copaxone, Extavia, Glatopa, or Plegridy

☐ Aubagio, Gilenya, or Tecfidera

☐ Other self-injectable or oral MS therapy (please specify)

☐ None of the above

Q9. For RRMS, how did the patient fail the MS therapies selected above?

☐ Continued clinical replapses (at least 1 relapse within 12 months)

☐ Continued CNS lesion progression as measured by MRI

☐ Worsening disability, such as decreased mobility, decreased ability to perform ADLs due to disease progression, or increase in EDSS score

☐ Other (please specify)

Q10. For RRMS, does the patient have clinically significant intolerance or contraindication to any of the following disease modifying therapies? Please select all that apply.

☐ Avonex, Copaxone, Extavia, Glatopa, or Plegridy

☐ Aubagio, Gilenya, or Tecfidera

☐ Other self-injectable or oral MS therapy (please specify)

☐ None of the above

Q11. For RRMS, will the patient have concurrent use of any other multiple sclerosis disease modifying agent (ex. Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Glatopa, Lemtrada, Rebif, Tecfidera, Tysabri, or Zinbryta)?

☐ Yes ☐ No

Q12. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

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☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q13. Provide name and NPI of the billing entity

Q14. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q15. Additional Comments

_____ _____

Prescriber Signature Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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