PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Lemtrada (alemtuzumab)

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. What is the patient's diagnosis?

- ☐ Relapsing form of multiple sclerosis
- ☐ Other (Please Specify)

Q2. Please provide the ICD code from the diagnosis provided.

Q3. Is member a NEW START to Lemtrada therapy?

☐ Yes ☐ No

Q4. Specify the prescriber's specialty.

- ☐ Neurologist
- ☐ Other (please specify)

Q5. Is the patient ≥18 years of age?

☐ Yes ☐ No

Q6. For initial request, does the patient have a contraindication to or failure of any of the following disease-modifying therapies? (Please select all that apply)

- ☐ Aubagio
- ☐ Avonex

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Lemtrada (alemtuzumab)

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:**

- ☐ Copaxone or Glatopa
- ☐ Extavia
- ☐ Gilenya
- ☐ Plegridy
- ☐ Tecfidera
- ☐ Tysabri
- ☐ None of the above

Q7. For initial request, have all other multiple sclerosis therapies been discontinued, including IVIG?

☐ Yes ☐ No

Q8. For initial request, does prescriber confirm that member will not receive more than the max allowable quantity of 12 mg x 5 days?

☐ Yes ☐ No

Q9. For continuation of therapy, has member received only 1 previous cycle of Lemtrada?

☐ Yes ☐ No

Q10. For continuation of therapy, have at least 365 days elapsed since last dose of previous cycle?

☐ Yes ☐ No

Q11. For continuation of therapy, please provide the date of previous Lemtrada cycle.

Q12. For continuation of therapy, has member re-initiated treatment with any other disease-modifying agents during the 12 months since first cycle, including IVIG?

☐ Yes ☐ No

Q13. If you answered "yes" to the previous question, please list all disease-modifying therapy used in the 12 months since the first cycle of Lemtrada was administered.

Q14. For continuation of therapy, does prescriber confirm that member will not receive more than the max allowable quantity of 12 mg x 3 days?

☐ Yes ☐ No

Q15. Additional Comments

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Lemtrada (alemtuzumab)

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:**

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 the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.