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 the patient a NEW START to Lemtrada therapy?

☐ Yes ☐ No

Q4. Specify the prescriber's specialty.

☐ Neurologist ☐ Other (please specify)

Q5. For initial request, does the patient have failure of an adequate trial of, clinically significant intolerance, or contraindication to any of the following disease-modifying therapies? (Please select all that apply)

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

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

Q6. For initial request, have all other multiple sclerosis therapies including IVIG been discontinued?

☐ Yes ☐ No

Q7. For initial request, does prescriber confirm that the patient will not receive more than the max allowable quantity of 12 mg x 5 days?

☐ Yes ☐ No

Q8. For continuation of therapy, has the patient received only 1 previous cycle of Lemtrada?

☐ Yes ☐ No

Q9. For continuation of therapy, have at least 365 days elapsed since last dose of previous cycle?

☐ Yes ☐ No

Q10. For continuation of therapy, please provide the date of previous Lemtrada cycle.

Q11. For continuation of therapy, has the patient re-initiated treatment with any other disease-modifying agents including IVIG during the 12 months since first cycle?

☐ Yes ☐ No

Q12. If "yes" to the previous question, please list all disease-modifying therapy used in the 12 months since the first cycle of Lemtrada was administered.

Q13. For continuation of therapy, does prescriber confirm that the patient will not receive more than the max allowable quantity of 12 mg x 3 days?

☐ Yes ☐ No

Q14. 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)

Q15. Provide name and NPI of the billing entity

Q16. 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

Q17. 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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	Prescriber Name:
Patient Name:	**Supervising Physician:**

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