

**Specialty Medication Prior Authorization Cover Sheet**

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to [www.uhcprovider.com](http://www.uhcprovider.com) for medication fax request forms.)

**Patient Information**

Patient's Name: \_\_\_\_\_

Insurance ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Sex:  Male  Female

**Provider Information**

Provider's Name: \_\_\_\_\_ Provider ID Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Suite Number: \_\_\_\_\_ Building Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Provider's Specialty: \_\_\_\_\_

**Medication Information**

Medication: \_\_\_\_\_ Quantity: \_\_\_\_\_ ICD10 Code: \_\_\_\_\_

Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Refills: \_\_\_\_\_

**Physician Signature\*\*:** \_\_\_\_\_ Initial here if DAW: \_\_\_\_\_

*Physician Signature\*\*:* By signing above, the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

**Medication Instructions**

Has the patient been instructed on how to **Self-Administer**?  Yes  No

Is this medication a **New Start**?  Yes  No

If continuation please provide the following: Initiation Date: / / Date of Last Dose: / /

Is there documentation of positive clinical response to current therapy?  Yes  No

**\*\*Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed.**

**Delivery Instructions**

**Note:** Delivery coordination requires a "Physician Signature" above and complete "Provider Information" and "Patient Information"

**Note:** All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

**Ship to:** Physician's Office  Patient's Address  Date medication is needed: / /

Medication Administered: Home Health  Self-Administered  LTC  Physician's Office

## Multiple Sclerosis - Ocrevus

### PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form contains multiple pages. Please complete all pages to avoid a delay in our decision.**

**Allow at least 24 hours for review.**

#### Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:

Primary Insurance Information:

Is the requested medication  New or  Continuation of Therapy? If continuation, list start date: \_\_\_\_\_

Is this patient currently hospitalized?  Yes  No If recently discharged, list discharge date: \_\_\_\_\_

#### Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:

Office Contact Name / Fax attention to:

#### Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:

Is this member pregnant?  Yes  No If yes, what is this member's due date? \_\_\_\_\_

#### Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:  
Please refer to the patient's PDL at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does any of the following apply to the patient?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Relapsing Remitting Multiple Sclerosis (RRMS) <input type="checkbox"/> Primary Progressive Multiple Sclerosis (PPMS)
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**RELAPSING REMITTING MULTIPLE SCLEROSIS (RRMS)**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has an appropriate wash-out period elapsed prior to planned treatment with Ocrevus (ocrelizumab)?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Was the patient previously treated with disease-modifying drugs with long lasting treatment effects (e.g., natalizumab, alemtuzumab)?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient concurrently taking other disease-modifying therapies for multiple sclerosis (MS)?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have negative test results for hepatitis B viral infection?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient's Expanded Disability Status Scale (EDSS) 6.5 or greater?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have imaging evidence of active disease?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have at least ONE documented relapsing event in the last 2 years?</b> <i>If yes, list:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there documentation that the provider has discussed the benefits and risks of continuing disease-modifying therapy?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Did the patient have an inadequate response to two or more medications FDA-approved for the same indication and/or medications that are considered the standard of care?</b> <i>(If yes, complete Section D above)</i>

**PRIMARY PROGRESSIVE MULTIPLE SCLEROSIS (PPMS)**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a diagnosis of PPMS according to the revised McDonald Criteria?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have documented oligoclonal IgG bands in cerebral spinal fluid?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient concurrently taking other disease-modifying therapies for multiple sclerosis (MS)?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have T2 lesions on brain or spinal cord imaging?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient in the ambulatory stage of disease [EDSS (Expanded Disability Status Scale) &lt; 7]?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient concurrently taking other disease-modifying therapies for multiple sclerosis (MS)?</b>

**CONTINUATION OF THERAPY**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a documented clinical benefit to therapy, as determined by the prescriber?</b> <i>If yes, list response:</i>
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**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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