Ocrevus (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. What is the diagnosis?
   - ❑ Relapsing form of multiple sclerosis (MS)
   - ❑ Primary progressive multiple sclerosis (PPMS)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ❑ Yes ❑ No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*
6. Is the medication prescribed by or in consultation with a neurologist? ❑ Yes ❑ No
7. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #11 (if applicable)*
8. Is the patient currently receiving the medication through samples or a manufacturer's patient assistance program? *If Yes, skip to #11 (if applicable)* ❑ Yes ❑ No
9. *If patient's diagnosis is relapsing form of multiple sclerosis*, has the patient experienced disease improvement or slowing of disease progression (eg, decrease in number of relapses, improvement or no decline in Kurtzke Expanded Disability Status Scale [EDSS] or in MRI findings) since initiating Ocrevus therapy? *If Yes, no further questions* ❑ Yes ❑ No ❑ N/A
10. *If patient's diagnosis is primary progressive multiple sclerosis*, has the patient experienced slowing of disease progression (eg, no decline in Kurtzke Expanded Disability Status Scale [EDSS] or MRI findings) since initiating Ocrevus therapy? *If Yes, no further questions* ❑ Yes ❑ No ❑ N/A

Complete the following questions if patient has Relapsing form of multiple sclerosis.

11. Is the patient newly diagnosed with MS? *If Yes, no further questions* ❑ Yes ❑ No
12. Is the patient new to treatment with disease modifying therapy? *If Yes, no further questions* ❑ Yes ❑ No
13. Is the patient's disease currently NOT stabilized on existing disease modifying therapy as evidenced by disease progression or occurrence of an intolerable adverse event? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**