

**Ocrevus**  
**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. Is the medication prescribed by or in consultation with a neurologist?  Yes  No
4. Is this request for continuation of therapy?  Yes  No *If No, skip to #8 (if applicable)*
5. Is the patient currently receiving the medication through samples or a manufacturer's patient assistance program?  
*If Yes, skip to #8 (if applicable)*  Yes  No
6. *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
7. *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.***

8. Is the patient newly diagnosed with MS? *If Yes, no further questions*  Yes  No
9. Is the patient new to treatment with disease modifying therapy? *If Yes, no further questions*  Yes  No
10. 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

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*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)**