



**Outpatient Medical Injectable
Ocrevus Authorization Request Form
Fax to 833-581-1861
(Medical Benefit Only)**

Member Name: _____ DOB: _____

Member ID (UMI): _____ Medicare Commercial

Address: _____

ORDERING/ATTENDING PROVIDER

Physician Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

SITE OF CARE

Place of Service (please select one)

Home Infusion Office – Professional Ambulatory Infusion Suite – Professional Outpatient Hospital

Is the site of care affiliated with a hospital or will the claim be billed as a facility claim? Yes No

Place of Service Name: _____ NPI: _____ Tax ID: _____

Address: _____

Drug Supplier (please select one)

Supplied by a Specialty Pharmacy (*for Home Infusion, Office – Professional, or Ambulatory Infusion Suite – Professional*) Pharmacy Name: _____ Pharmacy NPI: _____

Buy & Bill (*for Office – Professional or Outpatient Hospital administration*)

DRUG/DIAGNOSIS INFORMATION

Drug Name: **OCREVUS** Strength or Dose: _____ Date of service: _____

Directions: _____ Quantity (# of doses/visits): _____

Diagnosis code (ICD10): _____

****Please verify member's eligibility and benefits through the health plan****

Diagnosis Description (check one)

Relapsing Form of Multiple Sclerosis

(Includes relapsing-remitting, active secondary progressive disease or clinically isolated syndrome)

Primary Progressive Multiple Sclerosis based on the McDonald criteria

Note: McDonald criteria defined as: One or more years in which neurologic symptoms typical of multiple sclerosis progressively worsen and at least 2 of the following:

- Evidence of lesion dissemination in space in the brain based on greater than or equal to 1 T2 lesions in at least 1 area characteristic for MS periventricular, juxtacortical, or infratentorial; Gadolinium enhancement of lesions is not required; **or**
- Evidence of lesion dissemination in space in the spinal cord based on greater than or equal to 2 T2 lesions in the cord (Gadolinium enhancement of lesions is not required); **or**
- A documented history or presence of an elevated CSF IgG index or CSF oligoclonal band

Other: _____

CLINICAL INFORMATION

Does the member have documentation of an MRI of the brain showing abnormalities consistent with multiple sclerosis? YES NO

Is Ocrevus prescribed by or in consultation with a neurologist or provider who specializes in the treatment of multiple sclerosis? YES NO

Does the member have an active Hepatitis B virus infection? YES NO

Will the member receive any **LIVE** vaccines 4 weeks prior to and during treatment with Ocrevus?
 YES NO

Has the member had a life-threatening infusion reaction to Ocrevus? YES NO

New Start

Continuation of Therapy

Date of last infusion: _____

Please attach all pertinent clinical information

Attached: YES NO

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