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**