Outpatient Medical Injectable Ocrevus Authorization Request Form
Fax to 833-581-1861

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: ____

Phone Number: _____________________________Fax Number: _________________________________

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 (J2350)** 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
Is the member receiving Ocrevus in combination with another disease modifying therapy for MS? ☐ YES ☐ NO

☐ **New Start**	☐ **Continuation of Therapy**
	Date of last infusion: ______________________ • Has the member experienced a documented positive clinical response (e.g. reduction in annualized relapse rates, confirmed delay or improvement of disability progression, reduction in number or volume of lesions on MRI)? ☐ YES ☐ NO • Is the member receiving Ocrevus in combination with another disease modifying therapy for multiple sclerosis? ☐ YES ☐ NO

Please attach all pertinent clinical information

Attached: ☐ YES ☐ NO

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