Lemtrada

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.

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Patient's Name: ______________________________ **Date**: ________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** _____________________

<u>Rendering</u> Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** _____________________

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

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

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Exception Criteria Questions:

A. Is the requested product being prescribed for the treatment of a relapsing form of multiple sclerosis?
❑ Yes ❑ No, *skip to Clinical Criteria Questions*

B. The preferred product for your patient's health plan is Tysabri. Can the patient's treatment be switched to the preferred product?
❑ Yes, *Please obtain Form for preferred product and submit for corresponding PA.*
❑ No

C. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No, *skip to Question E*

D. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'. ❑ Yes ❑ No, *skip to Clinical Criteria Questions*

E. Has the patient had a documented inadequate response to treatment with the preferred product (Tysabri)? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Has the patient experienced a documented intolerable adverse event with the preferred product (Tysabri)? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have a documented contraindication to therapy with the preferred product (Tysabri) or any of its components? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No

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Criteria Questions:

1. What is the diagnosis?
   - ❑ Relapsing form of multiple sclerosis
   - ❑ Primary progressive multiple sclerosis (PPMS)
   - ❑ Other ____
2. What is the ICD-10 code? ________________

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

3. How many courses of Lemtrada treatment has the patient received over his/her lifetime?
   _____________ course (1 course = 5 doses; 2 courses = 8 doses; >2 courses = >8 doses)
4. Has the patient had an inadequate response to **two or more** drugs indicated for multiple sclerosis? ❑ Yes ❑ No
   If Yes, indicate drugs: ____

Step Therapy Override: Complete if Applicable.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	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)**

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