



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 copy or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering 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.

Required Demographic Information:

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Lemtrada SGM – 10/2018.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
Phone: 1-866-814-5506 • Fax: 1-855-330-1720 • www.caremark.com

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

Clinical 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?
_____ courses (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: _____

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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