PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Ocrevus® (ocrelizumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Ocrevus 300 mg/10 mL

Dose:_____ **Dose Frequency**:_____
Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Date of next dose: _____
Height: _____ **Weight**: _____

Place of administration:
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Facility: _____ NPI:_____ Fax:_____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Before this drug is covered, the patient must meet one of the following requirements:

1. A definitive diagnosis of Primary Progressive Multiple Sclerosis (PPMS) has been established by a neurologist or specialist in MS.
2. A diagnosis of multiple sclerosis (relapsing-remitting [RRMS] or secondary progressive MS) that has been established by a neurologist or specialist in MS.

*Documentation of a multiple sclerosis ICD10 code within the last 12 months must be submitted to Priority Health for commercial individual members. Approved ICD10 codes are provided in the Additional Information section.

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 08/2018
Last reviewed 01/2019

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Primary Progressive MS
- ☐ Relapsing-remitting MS
- ☐ Other – rationale for use: _____

B. What is the provider's specialty? _____

C. Will member be using Ocrevus in combination with another disease modifying agent for MS?

_____

Additional information

NOTE: Upon approval, Ocrevus may be authorized for a maximum of 2 years, annually for commercial individual members. Additionally, Ocrevus will not be approved in combination with any other disease modifying therapy for multiple sclerosis.

Approved ICD10 Codes for Multiple Sclerosis

ICD10	ICD10 Label
G35	Multiple sclerosis
G36.0	Neuromyelitis optica [Devic]
G37.0	Diffuse sclerosis of central nervous system
G37.5	Concentric sclerosis [Balo] of central nervous system

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