OPTUMRx®

OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Ocrevus® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Primary progressive multiple sclerosis (PPMS)
❑ Relapsing forms of multiple sclerosis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of prior Ocrevus therapy? ❑ **Yes** ❑ **No**
Has the patient used Ocrevus within the past 120 days? ❑ **Yes** ❑ **No**
Has hepatitis B virus (HBV) screening been performed? ❑ **Yes** ❑ **No**
Will Ocrevus be used in combination with another disease-modifying therapy for MS? ❑ **Yes** ❑ **No**
Will Ocrevus be used in combination with another B-cell targeted therapy [e.g., rituximab (Rituxan), belimumab (Benlysta), ofatumumab (Arzerra)]? ❑ **Yes** ❑ **No**
Will Ocrevus be used in combination with another lymphocyte trafficking blocker [e.g., alemtuzumab (Lemtrada), mitoxantrone]? ❑ **Yes** ❑ **No**

For relapsing forms of multiple sclerosis, also answer the following:

Does the patient have a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses)? ❑ **Yes** ❑ **No**

Select if the patient has had history of trial and failure following a trial for at least 4 weeks, contraindication, or intolerance to the following disease-modifying therapies for MS:

❑ Aubagio (teriflunomide)	❑ Gilenya (fingolimod)	❑ Rebif (interferon beta-1a)
❑ Avonex (interferon beta-1a)	❑ Glatiramer acetate	❑ Tecfidera (dimethyl fumarate)
❑ Betaseron (interferon beta-1b)	❑ Glatopa (glatiramer acetate)	❑ Tysabri (natalizumab)
❑ Copaxone (glatiramer acetate)	❑ Lemtrada (alemtuzumab)	❑ Zinbryta (daclizumab)
❑ Extavia (interferon beta-1b)	❑ Plegridy (peginterferon beta-1a)	

Is the patient not a candidate for any of the drugs listed above as prerequisites due to the severity of their MS? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to Ocrevus therapy? ❑ **Yes** ❑ **No**
Will Ocrevus be used in combination with another disease-modifying therapy for MS? ❑ **Yes** ❑ **No**
Will Ocrevus be used in combination with another B-cell targeted therapy [e.g., rituximab (Rituxan), belimumab (Benlysta), ofatumumab (Arzerra)]? ❑ **Yes** ❑ **No**
Will Ocrevus be used in combination with another lymphocyte trafficking blocker (e.g., alemtuzumab [Lemtrada], mitoxantrone])? ❑ **Yes** ❑ **No**

Ocrevus® Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.