Ocrevus, Ocrevus Zunovo

HMSACOM - Prior Authorization Request

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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** 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.

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:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

What product is being requested? ❑ Ocrevus ❑ Ocrevus Zunovo

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

CVS Caremark Specialty Programs ● 2969 Mapunapuna Place ● Honolulu, HI 96819
Phone: 1-808-254-4414 ● Fax: 1-866-237-5512 ● www.caremark.com

Criteria Questions:

1. What is the diagnosis?

❒ Relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse), *Continue to #2*

❒ Clinically isolated syndrome of multiple sclerosis, *Continue to #2*

❒ Primary progressive multiple sclerosis, *Continue to #2*

❒ Other, *Continue to #2*

2. Will the patient be taking the requested drug with any other disease modifying multiple sclerosis (MS) agent? (Note: Ampyra and Nuedexta are not disease modifying.)

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

3. Will the requested drug be prescribed by or in consultation with a neurologist?

❒ Yes, *Continue to #4*

❒ No, *Continue to #4*

4. What is the patient's age?

❒ Less than 18 years of age, *Continue to #5*

❒ Greater than or equal to 18 years of age, *Continue to #6*

5. Has the prescriber evaluated the risks and benefits of treatment and attests the benefits outweigh the risks?

❒ Yes, *Continue to #6*

❒ No, *Continue to #6*

6. Is this a request for continuation of therapy?

❒ Yes, *Continue to #8*

❒ No, *Continue to #7*

7. What is the requested drug?

❒ Ocrevus, *No Further Questions*

❒ Ocrevus Zunovo, *No Further Questions*

8. Is the patient experiencing disease stability or improvement while receiving the requested drug?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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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