# MEDICARE FORM

## Lemtrada® (alemtuzumab) Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**For Ohio MMP:**
**FAX:** 1-855-734-9389
**PHONE:** 1-855-364-0974

**For other lines of business:**
Please use other form.

**Note: Lemtrada is non-preferred. The preferred product is Tysabri for MA plans and Kesimpta for MAPD plans.**

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

**A. PATIENT INFORMATION**

| | | | |
|---|---|---|---|
| First Name: | Last Name: | | |
| Address: | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | E-mail: | |

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

**B. INSURANCE INFORMATION**

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

**C. PRESCRIBER INFORMATION**

| | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: | | | *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | |
| Address: | | City: | | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | Office Contact Name: | | | Phone: | |

**D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION**

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

**E. PRODUCT INFORMATION**

**Request is for Lemtrada: Dose:** _____ **Frequency:** _____ **HCPCS Code:** _____

**F. DIAGNOSIS INFORMATION** – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

**G. CLINICAL INFORMATION** – Required clinical information must be completed in its entirety for all precertification requests.

**For *All* Requests**

**Note: Lemtrada is non-preferred. The preferred product is Tysabri for MA plans and Kesimpta for MAPD plans.**

☐ Yes ☐ No Has the patient had prior therapy with Lemtrada (alemtuzumab) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to Tysabri (natalizumab)?
Please explain if there are any other medical reason(s) that the patient cannot use Tysabri (natalizumab).

_____

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to Kesimpta (ofatumumab)?
Please explain if there are any other medical reason(s) that the patient cannot use Kesimpta (ofatumumab).

_____

Please indicate the type of multiple sclerosis the patient has been diagnosed with:
☐ Relapsing-remitting (RRMS) ☐ Secondary-progressive MS (SPMS) ☐ Primary-progressive MS (PPMS) ☐ Progressive-relapsing MS (PRMS)
☐ Yes ☐ No Has the patient discontinued other medications used for treating MS (not including Ampyra)?
☐ Yes ☐ No Will a maximum of two courses of Lemtrada be utilized?
Please indicate the patient's HIV status: ☐ Positive ☐ Negative ☐ Unknown

**For *Continuation* requests:**

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Lemtrada?
☐ Yes ☐ No Does the patient have a documented severe and/or potentially life threatening adverse event that occurred during or following the previous infusion?
→ ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the office setting?

***Continued on next page***

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.