AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Lemtrada® (alemtuzumab) (J-0202) (Medical)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

When approved, the covered dose is **5 infusions during Year 1** (12 mg daily on 5 consecutive days), followed by **3 infusions in Year 2** (12 mg daily on 3 consecutive days). Subsequent infusions **(Year 3 and beyond)** of 12 mg daily on 3 consecutive days may be approved based on medical necessity.

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Multiple Sclerosis (MS) Indication**

- ❑ Prescriber is a Neurologist

(Continued on next page)

- ❑ Member has a confirmed diagnosis of relapsing-remitting MS
- ❑ Member has had at least **one** medically documented clinical relapse within the previous 12 months
- ❑ Provider is registered with the Lemtrada® REMS program
- ❑ Member has tried and failed **at least TWO (2)** of the following drugs **(check all tried):**

❑ Aubagio® (teriflunomide)	❑ Kesimpta® (ofatumumab)
❑ Avonex® (IFN beta-1b)	❑ Mavenclad® (cladribine)
❑ Bafiertam™ (monomethyl fumarate)	❑ Mayzent® (siponimod)
❑ Betaseron® (IFN beta-1a)	❑ Plegridy® (pegylated-IFN beta-1a)
❑ Copaxone® (glatiramer acetate)	❑ Rebif® (IFN beta-1a)
❑ Extavia® (IFN beta-1a)	❑ Vumerity® (diroximel fumarate)
❑ Gilenya® (fingolimod)	❑ Zeposia® (ozanimod)
❑ Tecfidera® (dimethyl fumarate)	
❑ Tysabri® (natalizumab) **requires prior authorization**	

For Infusions Year 3 and beyond: All criteria must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Prescriber is a Neurologist
- ❑ Member has a confirmed diagnosis of relapsing-remitting MS
- ❑ Member's last Lemtrada® infusion was at least 12 months ago
- ❑ Member has had at least **one** medically documented clinical relapse within the previous 12 months with disease progression
- ❑ Provider is registered with the Lemtrada® REMS program

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy and Therapeutics Committee**: 3/19/2015
REVISED/UPDATED: 6/24/2015; 12/8/2015; 12/28/2015; 1/29/2016; 8/10/2016; 9/22/2016; 12/11/2016; 5/30/2017; 6/8/2017; 7/24/2017; (Reformatted) 3/17/2019; 7/7/2019; 9/24/2019; 10/8/2019; **6/30/2021**