MEDICARE FORM

Lemtrada® (alemtuzumab) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857

For other lines of business: Please use other form.

Note: Lemtrada is non-preferred. The preferred product is Tysabri.

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:
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.

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

____

____

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
☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Is the patient medically unstable for infusions at alternate levels of care?
☐ Yes ☐ No Does the patient have a history of any cardiopulmonary conditions?
→ Please provide the description of the condition: ______________
☐ Yes ☐ No Does this condition cause an increased risk of severe adverse reactions?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

☐ Yes ☐ No Does the patient have documentation of unstable vascular access?

☐ Yes ☐ No Is there clinical evidence that the patient has an inability to safely tolerate intravenous volume load (including from unstable renal function)?

→ ☐ Yes ☐ No Is the inability to tolerate intravenous volume load due to unstable renal function?

→ Please document the following:
- ☐ GFR:_____ mL/min/1.73m^2 Date Collected: _____/_____/_____
- ☐ BUN:_____ mg/dL Date Collected: _____/_____/_____
- ☐ Creatinine:_____ mg/dL Date Collected: _____/_____/_____

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?

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.