



# MEDICARE FORM

## Lemtrada® (alemtuzumab) Medication Precertification Request

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

Virginia (HMO D-SNP):  
FAX: 1-833-280-5224  
PHONE: 1-855-463-0933

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 #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____

### C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b>		<b>Dispensing Provider/Pharmacy:</b>	
<input type="checkbox"/> Self-administered	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Retail Pharmacy
<input type="checkbox"/> Outpatient Infusion Center	Phone: _____	<input type="checkbox"/> Specialty Pharmacy	<input type="checkbox"/> Mail Order
Center Name: _____		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Home Infusion Center	Phone: _____	Name: _____	
Agency Name: _____		Address: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		Phone: _____ Fax: _____	
Address: _____		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

#### 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?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**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.