



MEDICARE FORM

Lemtrada® (alemtuzumab) Medication Precertification Request

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

For Medicare Advantage Part B:
Phone: [1-866-503-0857](tel:1-866-503-0857) (TTY: [711](tel:711))
FAX: [1-844-268-7263](tel:1-844-268-7263)

For other lines of business:
Please use other form.

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

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.