

MEDICARE FORM

Lemtrada® (alemtuzumab) Medication Precertification Request

Page 1 of 2 (All fields must be completed and legible for precertification review.) Start of treatment: Start date // / Please indicate:

For Medicare Advantage Part B: Phone: <u>1-866-503-0857</u> (TTY: <u>711</u>) FAX: <u>1-844-268-7263</u>

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

∟ Precertification Requ	ested By:	erapy: Date of I	ast treatment	Phone:		MAPD plans. Fax:		
A. PATIENT INFORMAT	TION							
First Name:			La	ast Name:				
Address:			Ci	ty:		State:	ZIP:	
Home Phone:		Work Ph	one:		Cell Phone:	- !		
DOB:	Allergies:				E-mail:			
Current Weight:	lbs or	kgs	Height:	inches or	cms	}		
B. INSURANCE INFOR								
Aetna Member ID #:		Do	oes patient have oth	ner coverage?	Yes 🗌 No			
Group #:				Ca				
Insured:		_	sured:					
C. PRESCRIBER INFO	RMATION							
First Name:		La	st Name:		(Check Or	ne): 🔲 M.D. 🛭] D.O. [] N.P. []	P.A.
Address:		1		City:		State:	ZIP:	
Phone:	Fax:	St	Lic #:	NPI#:	DEA #:		UPIN:	
Provider Email:		Office (Contact Name:		Phone:			
D. DISPENSING PROVI	IDER/ADMINISTRATI	ON INFORMATI	ON					
Place of Administration: Self-administered Outpatient Infusion Center Name: Home Infusion Center Agency Name Administration code Address: City: Phone: TIN: NPI: E. PRODUCT INFORMA	Physician' Center Phone ter Phone : g(s) (CPT): State Fax PIN	e: ZIP	:	_ Phone: _ TIN: _ NPI:	ifice [rmacy [State: Fax: PIN:	ZIP:	
F. DIAGNOSIS INFORM					le	1101 00 000	ic	
Primary ICD Code:						Jode.		
G. CLINICAL INFORMA For Initiation Request: Note: Lemtrada is not Yes No Has tr Yes No Has tr Please explain if there	s: n-preferred. The pre ne patient had prior the ne patient had a trial	eferred product nerapy with Lem and failure, intol	t is Ocrevus for Ma ntrada (alemtuzuma lerance, or contrain	A plans and Kesimpt lb) within the last 365 dication to Ocrevus (o	a for MAPD pl days? crelizumab)?			
☐ Yes ☐ No Has Please explain if there	are any other medica	al reason(s) that	the patient cannot			?		
☐ Relapsing-remitting ☐ Yes ☐ No Has th ☐ Yes ☐ No Will a Please indicate the pat	(RRMS)	dary-progressive ed other medica urses of Lemtrac	e MS (SPMS) ☐ F itions used for treat da be utilized?	Primary-progressive Ming MS (not including		Progressive-r	relapsing MS (PRI	√IS)
For Continuation requ		4						
previo	the patient have a do ous infusion?	ocumented seve	re and/or potentiall	mples of Lemtrada? y life threatening adve			ng or following the	



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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.