PRIOR AUTHORIZATION FORM
Ocrevus - Commercial

Unless otherwise indicated below, authorization quantities are limited to the manufacturer recommended dosage

SCRIPIUS
a service of selecthealth.

P.O. Box 30192 Salt Lake City, UT 84130

Complete online at www.selecthealth.org/pa or fax back to: 801-650-3279 **For questions or clarifications, call: 800-442-3129**	
Patient Information	
Patient's Name:	Patient's Date of Birth:
Patient's ID:	Patient's Phone #:
Diagnosis Code(s):	
Requesting Provider Information	
Name:	Phone #:
NPI/DEA:	Fax #:
Address:	Supervising Physician (if requesting provider bills under a different provider)
	Name:
	NPI/DEA:
Servicing Provider Information (if different than requesting provider)	
Name of provider or facility:	Phone number:
NPI/DEA:	Address:

Drug Name and Strength:	Directions / SIG:

Q1. Will Ocrevus be administered at Logan Regional or St. George Regional Hospital?

Note, this drug is not covered at Logan Regional or St. George Regional Hospital

☐ Yes ☐ No

Q2. Is this a reauthorization request?

☐ Yes ☐ No

Q3. What is the patient's diagnosis?

☐ Active forms of secondary progressive multiple sclerosis (aSPMS)
☐ Clinically isolated syndrome (CIS)
☐ Primary progressive multiple sclerosis (PPMS)
☐ Relapsing remitting multiple sclerosis (RRMS)
☐ Other

Q4. If other, please specify:

Q5. Will Ocrevus be used in combination with any other multiple sclerosis disease-modifying therapies (i.e., dimethyl fumarate, Ocrevus, Tysabri, etc.)?

☐ Yes ☐ No

Q6. Has a differential diagnosis of neuroinflammatory disease, such as neuromyelitis optica (NMO), been excluded?

☐ Yes ☐ No

Q7. Will Ocrevus be used in combination with another biologic medication, JAK inhibitor or Otezla?

☐ Yes ☐ No

Q8. Was the patient's diagnosis of RRMS supported by the 2017 McDonald diagnostic criteria?

Please select the appropriate diagnostic finding below based on the number of attacks, number of lesions, and additional clinical criteria needed:

☐ Two attacks PLUS two lesions on MRI
☐ Two attacks, one lesion, and evidence of dissemination in space on MRI
☐ One attack, two lesions, and evidence of dissemination in time on MRI
☐ One attack, one lesion, and evidence of dissemination in space AND time on MRI, OR demonstration of CSF-specific oligoclonal bands
☐ One attack, one lesion, and evidence of dissemination in space on MRI AND demonstration of CSF-specific oligoclonal bands
☐ None of the above

Q9. For new starts only, have the MRI findings been reviewed and interpreted by a radiologist to confirm the diagnosis and findings?

Please note: MRI and radiologist interpretation must be submitted

☐ Yes ☐ No

Q10. Has the patient been compliant on at least one of the following preferred generic MS drugs?

☐ Dimethyl fumarate
☐ Fingolimod
☐ Glatiramer acetate (Glatopa)
☐ Teriflunomide
☐ None of the above

Q11. If none, does the patient have a highly active disease?

☐ Yes ☐ No

Q12. If no, does the patient have elevated risk for progression to highly active multiple sclerosis based one of the following clinical factors?

☐ Onset or diagnosis after age of 40 ☐ Short inter-attack interval of relapse

☐ Expanded Disability Status Scale (EDSS) more than or equal to 3 within the first
year of diagnosis
☐ High T2 lesion load, gadolinium enhancing lesions, or T1 lesions at diagnosis
☐ Infratentorial lesions (cerebellum, brain stem, or spinal cord) at diagnosis
☐ Partial or incomplete recovery or multifocal attack
☐ Relapse requiring hospitalization or administration of corticosteroids
☐ Rapid accumulation of disability
☐ None of the above

Q13. Chart Notes are required for the request of this medication. Failure to provide chart notes will result in a delay in decision and/or denial. Did you attach relevant chart notes?

☐ Yes ☐ No

Q14. Additional comments:

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-650-3279. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

_____ _____

Prescriber Signature Date