Neighborhood Health Plan OF RHODE ISLAND™

Lemtrada Authorization form
J0202

Tel. 401-427-8200; Fax 844-639-7906

Lemtrada (alemtuzumab) Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:
REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:

ICD 10 Codes:

Clinical Assessment (provide all required information and clinical documentation)	YES	NO
Is the patient diagnosed with a relapsing form of multiple sclerosis and documented by laboratory report (i.e. MRI)?	☐	☐
Has the patient failed, demonstrated intolerance, or is contraindicated to at least two drugs indicated for the treatment of relapsing MS?	☐	☐
Is the Lemtrada (alemtuzumab) prescribed by a neurologist?	☐	☐
Will Lemtrada (alemtuzumab) be used as monotherapy for the treatment of relapsing forms of MS	☐	☐
Will the dose exceed 12 billable units per dose or (1 dose daily for 5 days(60 billable units), followed by 1 dose daily for 3 days(36 billable units, one year later)?	☐	☐
Note: Coverage cannot be renewed		

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Requesting Provider:	**Date:**

Authorization is not a guarantee of payment. Member must be eligible at time of service.