Neighborhood Health Plan OF RHODE ISLAND™

Ocrevus Authorization form
J2350

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

Ocrevus (ocrelizumab) 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 at least 18 years of age?	☐	☐
Is the patient diagnosed with primary progressive multiple sclerosis (PPMS) or relapsing form of multiple sclerosis as documented by laboratory report (i.e. MRI)?	☐	☐
Is the Ocrevus (ocrelizumab) prescribed by a neurologist?	☐	☐
Will the Ocrevus (ocrelizumab) be used as a single agent?	☐	☐
For members with relapsing forms of multiple sclerosis, they will need to provide documentation of one of the following: • The Member is newly diagnosed with relapsing multiple sclerosis **OR**	☐	☐
• The Member's current or previous disease modifying therapy does not adequately control the disease as evidenced by disease progression or the member is experiencing intolerable adverse events	☐	☐
Does the initial dose exceed 300mg(300 billable units) followed two weeks later by a second dose of 300 mg (300 billable units)?	☐	☐

If this request is for the maintenance dose, does the dose exceed 600mg (600 billable units) every 6 months?	☐	☐
Continuation of therapy for patients with PPMS or RRMS:	☐	☐
Is patient tolerating treatment?	☐	☐
Has the patient received a dose of ocrelizumab within the past 5 months?	☐	☐
Has the patient has experienced a slowing of disease worsening (eg, no decline in Expanded Disability Status Score [EDSS] or MRI findings) since initiating therapy?	☐	☐

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.