COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Elixir Multiple Sclerosis-15 STD/SELECT PA-ST-AJ

Phone: 800-361-4542 Fax back to: 866-414-3453

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Please note that Elixir will process the request as written, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:

- ☐ RRMS (Relapsing Remitting Multiple Sclerosis)
- ☐ PRMS (Progressive Relapsing Multiple Sclerosis)
- ☐ PPMS (Primary Progressive Multiple Sclerosis)
- ☐ SPMS (Secondary Progressive Multiple Sclerosis)
- ☐ Clinically Isolated Multiple Sclerosis
- ☐ Crohn's Disease (Tysabri only)
- ☐ Other

Q4. For CROHN'S DISEASE, please select all that apply to the patient:

- ☐ Prescriber attests that patient has a documented diagnosis of moderate to severe Crohn's disease
- ☐ Prescriber attests that patient has tried, failed or is intolerant to conventional therapy (mesalamine, antibiotics, steroids, immunomodulators, azathioprine)
- ☐ Prescriber attests that patient has tried, failed or is intolerant to anti-TNF alfa therapy (infliximab, adalimumab, certolizumab)
- ☐ None of the above

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Q5. If the patient's diagnosis is OTHER, please specify below:

Q6. Has the patient had trial and failure, contraindication, or intolerance to any of the following? Please select all that apply:

- ☐ Aubagio
- ☐ Avonex
- ☐ Bafiertam
- ☐ Betaseron
- ☐ Copaxone 40 mg
- ☐ Dimethyl fumarate
- ☐ Gilenya
- ☐ Glatiramer 20 mg or 40 mg
- ☐ Plegridy
- ☐ Vumerity
- ☐ Zeposia
- ☐ Other
- ☐ None of the above

Q7. If the medication is OTHER, please specify below:

Q8. If the patient has NOT tried any of the medications listed in the previous question(s), is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q9. For OCREVUS, please select all that apply to the patient:

- ☐ Prescriber attests to laboratory documentation that patient is NOT a Hepatitis B virus (HBV) carrier
- ☐ Prescriber attests that if patient IS a HBV carrier, a consultation with a liver expert (gastroenterologist, hepatologist, or infectious disease specialist) has occurred
- ☐ Prescriber attests to documentation that at least one formulary disease-modifying therapy for multiple sclerosis is contraindicated or not tolerated
- ☐ Prescriber attests to documentation that at least one formulary disease-modifying therapy for multiple sclerosis was ineffective
- ☐ None of the above
- ☐ Not applicable - this request is not for Ocrevus

Q10. Please indicate the patient's age:

- ☐ 9 years of age or younger
- ☐ 10 to 17 years of age
- ☐ 18 years of age or older

Q11. Is the requested medication prescribed by or in conjunction with any of the following?

- ☐ Gastroenterologist
- ☐ Multiple sclerosis specialist
- ☐ Neurologist
- ☐ None of the above

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Q12. Does the patient have any of the following exclusions? Please select all that apply:

- ☐ Concurrent use of any another disease modifying agent (DMA) indicated for the treatment of multiple sclerosis
- ☐ Any FDA labeled contraindication(s) to therapy with the requested agent
- ☐ Active Hepatitis B virus (HBV) infection
- ☐ History of life-threatening infusion reaction to Ocrevus
- ☐ Pregnancy
- ☐ Current or history of PML
- ☐ Medication will be used in combination with immunosuppressants or inhibitors of TNF-alpha in Crohn's disease
- ☐ None of the above

Q13. For RENEWAL, please select all that apply:

- ☐ Prescriber attests that patient has had disease improvement or stabilization with medication
- ☐ Prescriber attests that patient has shown benefit from therapy by 12 weeks of induction therapy (Crohn's Disease only)
- ☐ Prescriber attests that patient has been able to demonstrate a discontinuation of chronic concomitant steroids within 6 months of starting therapy (Crohn's Disease only)
- ☐ None of the above

Prescriber Signature

Date