

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.

Member/Subscriber Number: Date of Birth: Group Number: Address: City, State ZIP: Primary Phone: *Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent Drug Name and Strength:				
Date of Birth: Group Number: Address: City, State ZIP: Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	Patient Name:	Prescriber Name:		
Group Number: Address: Address: City, State ZIP: Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	Member/Subscriber Number:	Fax:	Phone:	
Address: City, State ZIP: City, State ZIP: Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. 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 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) PRMS (Progressive Relapsing Multiple Sclerosis) PRMS (Secondary Progressive Multiple Sclerosis) Corbin's Disease (Tysabri only) Other Q4. For CROHN'S DISEASE, please select all that apply to the patient: Prescriber attests that patient has tried, failed or is intolerant to conventional therapy (infliximab, adalimumab, certolizumab)	Date of Birth:	Office Contact:		
City, State ZIP: Primary Phone: **Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	Group Number:	NPI:	State Lic ID:	
Primary Phone: *Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	Address:	Address:		
*Please note that Elixir will process the request as written, including drug name, with no substitution. Expedited/Urgent	City, State ZIP:	City, State ZIP:		
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	Primary Phone:	Specialty/facility name (if applicable):		
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	*Please note that Elixir will process the request as writte	en, including drug name, with no	substitution.	
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		☐ Expedited/Urgent		
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	Drug Name and Strength:			
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				
Q1. Is this request for initial or continuing therapy? Initial therapy	Directions / SIG:			
Q1. Is this request for initial or continuing therapy? Initial therapy	Places attach any partinent medical history or information	o for this nations that may support an	poroval Places answer the	
□ 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)				
□ 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)				
□ 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)				
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)	Q1. Is this request for initial or continuing therapy?			
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)	☐ Initial therapy	☐ Continuing therapy		
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)	O2 For CONTINUING THERAPY, please provide the start date (MM/VV):			
☐ 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)	Q2. For CONTINUING THERAFT, please provide the start date (MIN/TT).			
☐ 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)	OO Disass in the state the state the state of the state o	and the action of the second		
 □ 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) 		ed medication:		
 □ 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) 				
 □ 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) 				
 ☐ 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) 	, , , , , , , , , , , , , , , , , , , ,			
 ☐ 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) 				
☐ 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)				
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)				
 □ 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) 	│			
☐ 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)	Q4. For CROHN'S DISEASE, please select all that appl	y to the patient:		
☐ 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)	Prescriber attests that patient has a documented	diagnosis of moderate to severe C	Crohn's disease	
steroids, immunomodulators, azathioprine) ☐ Prescriber attests that patient has tried, failed or is intolerant to anti-TNF alfa therapy (infliximab, adalimumab, certolizumab)		=		
certolizumab)	· ·	·		
	Prescriber attests that patient has tried, failed or	is intolerant to anti-TNF alfa therap	y (infliximab, adalimumab,	
☐ None of the above				
	☐ None of the above			



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:	
Q5. If the patient's diagnosis is OTHER, please specify below:		
Q6. Has the patient had trial and failure, contraindication, capply: Aubagio Avonex Bafiertam Betaseron Copaxone 40 mg Dimethyl fumarate Gilenya	or intolerance to any of the following? Please select all that 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 conjuct Gastroenterologist Multiple sclerosis specialist Neurologist None of the above	nction with any of the following?	



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:	
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 immuno☐ None of the above	suppressants or inhibitors of TNF-alpha in Crohn's disease	
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	

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document