SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Ocrevus® (ocrelizumab) **Injection (J2350/C9494) (Medical)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Recommended Dosage and Administration:

- **Initial dose: 300 mg intravenous infusion, followed 2 weeks later by a 2nd 300 mg intravenous infusion**
- **Subsequent doses: single 600 mg intravenous infusion every 6 months**

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis - Primary Progressive Multiple Sclerosis (MS)**

- ❑ Prescriber is a Neurologist
- ❑ Member has a confirmed diagnosis of Primary Progressive MS

(Continued on next page)

❑ Diagnosis - Relapsing-Remitting MS indication

- ❑ Prescriber is a Neurologist
- ❑ Member has a confirmed diagnosis of relapsing-remitting MS
- ❑ Member has had at least one medically documented clinical relapse within the previous 12 months
- ❑ Member has tried and failed at least **ONE (1)** of the following agents **(verified by chart notes or pharmacy paid claims; check each tried):**

❑ Aubagio® (teriflunomide)	❑ Avonex® (IFN beta-1b)	❑ Bafiertam® (monomethyl fumarate)
❑ Betaseron® (IFN beta-1a)	❑ Copaxone® (glatiramer acetate)	❑ Extavia® (IFN beta-1a)
❑ Gilenya® (fingolimod)	❑ Kesimpta® (ofatumumab)	❑ Lemtrada® (alemtuzumab) **(requires medical prior authorization)**
❑ Mavenclad® (cladribine)	❑ Mayzent® (siponimod)	❑ Plegridy® (pegylated-IFN beta-1a)
❑ Rebif® (IFN beta-1a)	❑ Tecfidera® (dimethyl fumarate)	❑ Tysabri® (natalizumab) **(requires medical prior authorization)**
❑ Vumerity® (diroximel fumarate)	❑ Zeposia® (ozanimod)	

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by the Pharmacy and Therapeutic Committee**: 5/18/2017
REVISED/UPDATED/REFORMATTED: ~~5/30/2017; 6/30/2017; 8/6/2017; 12/12/2017; 9/28/2018; 3/18/2019; 7/7/2019; 9/24/2019; 6/30/2021; 5/13/2022; 6/4/2022;~~ **6/17/2022**