COVERAGE DETERMINATION REQUEST FORM

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

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)
- ☐ Crohn's Disease (Tysabri only)
- ☐ Clinically Isolated Multiple Sclerosis
- ☐ Other

Q4. For CROHN'S DISEASE, please check all that apply to this patient:

- ☐ Prescriber attests that patient has a documented diagnosis of moderate to severe Crohns disease
- ☐ Prescriber attests that patient has tried, failed or intolerant to conventional therapy (mesalamine, antibiotics, steroids, immunomodulators, azathioprine)
- ☐ Prescriber attests that patient has tried, failed or intolerant to anti-TNF alfa therapy (infliximab, adalimumab, certolizumab)
- ☐ Tysabri will not be used in combination with immunosuppressants or inhibitors of TNF-alpha

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☐ None of the above

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

Q6. Please indicate which medication this request is for:

☐ Aubagio
☐ Avonex
☐ Betaseron
☐ Copaxone
☐ Extavia
☐ Gilenya
☐ Glatiramer
☐ Glatopa
☐ Lemtrada
☐ Ocrevus
☐ Plegridy
☐ Rebif
☐ Tecfidera
☐ Tysabri
☐ Vumerity
☐ Other

Q7. For OCREVUS, please select all that apply to this 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 two (2) formulary disease-modifying therapies for multiple sclerosis are contraindicated or not tolerated

☐ Prescriber attests to documentation that at least two (2) formulary disease-modifying therapies for multiple sclerosis were ineffective, defined as meeting at least two (2)of the following:
The patient continues to have clinical relapses (at least two relapses within the past 12 months) OR
The patient continues to have CNS lesion progression as measured by MRI OR continues to have worsening disability. Examples of worsening disability include, but are not limited to, decreased mobility, decreased ability to perform activities of daily living due to disease progression, or EDSS greater than 3.5

☐ None of the above

Q8. If the medication is Other, please specify below:

Q9. Is the requested medication prescribed by (or in consultation with) any of the following?

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

Q10. Will the patient be concurrently using any another disease modifying agent (DMA) indicated for the treatment of multiple sclerosis?

☐ Yes ☐ No

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Q11. Does the patient have any FDA labeled contraindications to therapy with the requested agent?

☐ Yes ☐ No

Q12. Has the patient previously tried and failed any of the following medications?

☐ Aubagio
☐ Avonex
☐ Betaseron
☐ Copaxone
☐ Gilenya
☐ Plegridy
☐ Tecfidera
☐ Other
☐ None of the above

Q13. If the medication is OTHER, please specify below:

Q14. If the patient has NOT tried any of the medications listed in the previous question, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

Q15. Does the patient have any of the following EXCLUSIONS?

☐ Current or history of PML
☐ Active Hepatitis B virus (HBV) infection
☐ History of life-threatening infusion reaction to Ocrevus
☐ Pregnancy
☐ None of the above

Q16. Please indicate the patient's age:

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

Q17. FOR RENEWAL, Please check all that apply:

☐ The prescriber attests that the patient has had disease improvement or stabilization since using the medication
☐ The prescriber attests that the patient has shown benefit from therapy by 12 weeks of induction therapy (ONLY FOR CROHNS)
☐ The prescriber attests that patient has been able to demonstrate a discontinuation of chronic concomitant steroids within 6 months of starting therapy (ONLY FOR CROHNS)
☐ None of the above

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date