aetna®

MEDICARE FORM

Lemtrada® (alemtuzumab) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

For Virginia HMO SNP:
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

Note: Lemtrada is non-preferred. The preferred product is Tysabri.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Lemtrada: Dose: _____ **Frequency:** _____ **HCPCS Code:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For *All* Requests
Note: Lemtrada is non-preferred. The preferred product is Tysabri.
☐ Yes ☐ No Has the patient had prior therapy with Lemtrada (alemtuzumab) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Tysabri (natalizumab)?
Please explain if there are any other medical reason(s) that the patient cannot use Tysabri (natalizumab).

_____

_____

Please indicate the type of multiple sclerosis the patient has been diagnosed with:
☐ Relapsing-remitting (RRMS) ☐ Secondary-progressive MS (SPMS) ☐ Primary-progressive MS (PPMS) ☐ Progressive-relapsing MS (PRMS)
☐ Yes ☐ No Has the patient discontinued other medications used for treating MS (not including Ampyra)?
☐ Yes ☐ No Will a maximum of two courses of Lemtrada be utilized?
Please indicate the patient's HIV status: ☐ Positive ☐ Negative ☐ Unknown

For *Continuation* requests:
☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Lemtrada?
☐ Yes ☐ No Does the patient have a documented severe and/or potentially life threatening adverse event that occurred during or following the previous infusion?
→ ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the office setting?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.