US Family Health Plan

Prior Authorization Request Form for

Ofatumumab injection (Kesimpta)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Clinical documentation may be required. Failure to provide could result in denial.
Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to Question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a neurologist?	☐ Yes Proceed to Question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication or diagnosis is the requested medication being prescribed?	☐ Relapsing forms of MS - Proceed to Question **4** ☐ Other - **STOP Coverage not approved**	
4. Is the patient currently using another disease-modifying therapy (for example, interferon, glatiramer, Tecfidera, Vumerity, Aubagio, Gilenya, Mayzent, Zeposia, Mavenclad, etc.)	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **5**
5. Does the patient have an active hepatitis B virus infection?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **6**
6. Has the patient failed a course of Ocrevus?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

[10 February 2021]

Prescriber Signature _____ Date _____