Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
KESIMPTA (Ofatumumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **KESIMPTA (Ofatumumab).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a Neurologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____
2. Indicate the Member's diagnosis for the requested medication: _____
3. Does the member have a diagnosis of relapsing form of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting, active secondary progressive disease)? **AND**
   □ No □ Yes
4. Member is not on another DMT? **AND**
   □ No □ Yes
5. Member has failed an adequate trial (≥3 months) of, or has a documented allergy or intolerance to, or is not a candidate for Truxima (rituximab-abbs)? **AND**
6. Member has failed an adequate trial (≥3 months) of, or has a documented allergy or intolerance to, or is not a candidate for Ocrevus?
   □ No □ Yes

For Continuation of Therapy, Please Respond to Additional Questions Below:

1. Does member continue to meet criteria listed above? **AND**
   □ No □ Yes
2. Member has completed the following laboratory monitoring within the last 6 months:
   a. Quantitative serum immunoglobulins
   b. Complete blood count with differential
   c. Liver function
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**