

# Elderplan Part B Drug Step Therapy Program

Effective January 1, 2022



## Non-Preferred Part B Drug Request Form: Lemtrada

If you would like to request a Non-Preferred Part B Drug, please complete this form and fax it to Elderplan's Pharmacy Department at 929-275-3223.

Member Information	
Member ID:	
Member Name:	
Date of Birth:	
Street Address:	
City/State/Zip:	
Member Phone #:	

Prescriber Information	
Prescriber Name:	
NPI #:	
Tax ID #:	
Address:	
City/State/Zip:	
Phone #:	
Fax #:	

Please consider the Preferred Drug for the member's treatment before proceeding to a drug that is on Elderplan's Non-Preferred Drug list.

Multiple Sclerosis (Infused)	
Step 1 Drug (Preferred) <i>No Authorization Required</i>	<ul style="list-style-type: none"><li>Tysabri (natalizumab)</li></ul>
Step 2 Drug (Non-Preferred) <i>Authorization Required</i>	<ul style="list-style-type: none"><li>Lemtrada (alemtuzumab)</li></ul>

**Non-Preferred Drug Exception Questions:**

**Please answer ALL questions below.**

A. What is the name of the Step 2 (Non-Preferred) Drug that is being requested? \_\_\_\_\_

B. What is the dosing regimen for the requested Non-Preferred Drug (specify drug name, drug strength, units per dose, frequency, days supply, and duration of therapy)?  
\_\_\_\_\_

C. What is the ICD-10 code for the requested Non-Preferred Drug? \_\_\_\_\_

D. What is the NDC of the requested Non-Preferred Drug? \_\_\_\_\_

E. Has the member received treatment with the requested Non-Preferred Drug in the past 365 days?  
 Yes  No

F. Has the member had a documented inadequate response, intolerance, or contraindication to therapy with the preferred drug, **Tysabri**, or any of its components?  
 Yes  No

➤ *Please explain below or attach supporting documentation:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Elderplan will review this initial request and provide our decision within our standard timeframe of 72 hours.**

**If waiting the 72 hours standard timeframe may jeopardize the life or health of the member and an expedited decision within 24 hours is medically necessary, please explain below.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prescriber's Signature**

**Date**

**Please fax this form to 929-275-3223 (Elderplan Pharmacy Department) upon completion.**

If you have any questions or concerns, contact us at 718-630-2601 or 718-921-8841, Monday through Friday from 9 AM to 5 PM. A copy of Elderplan's Part B Step Therapy Program Drug List is located on Elderplan's Provider Web Portal and our website at <https://www.elderplan.org/for-providers/>.

Thank you,  
Elderplan Pharmacy Department