

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

## **Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Kesimpta (ofatumumab).** <u>Please complete all sections, incomplete forms will delay processing.</u> <u>Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104</u>. 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: <a href="http://www.providers.kaiserpermanente.org/mas/formulary.html">http://www.providers.kaiserpermanente.org/mas/formulary.html</a>

	1 – Patient Information		
Patient Name:	Kaiser Medical ID#:	Date of Birth:	
2 – Prescriber Information			
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		
Is this request for initial or continuing    Initial therapy	therapy?		

2.	Indicate the patient's diagnosis for the requested medication:		
3.	Is this a treatment of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults? □ No □ Yes □		
4.	Has the patient tried the brand Tecfidera?		
	□ No □ Yes		
	6 – Prescriber Sign-Off		
Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. If no to any of the above questions, please 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.			
Pre	criber Signature: Date:		
priv	e Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information te and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking ction in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facili	of	

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Prior Authorization Form
Revision date: 5/26/2021; Effective 7/1/2021
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