PRIOR AUTHORIZATION REQUEST
Multiple Sclerosis Agents

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - ☐ INITIAL - **please answer questions 2-5**
   - ☐ CONTINUATION - **please answer question 14**
2. ☐ Yes ☐ No Is the requested medication being prescribed by a neurologist?
3. ☐ Yes ☐ No Will the requested medication be used in combination with other disease-modifying agents used for multiple sclerosis (MS) (for example, Avonex, Rebif, Betaseron, Extavia, Copaxone, Glatopa, Plegridy, Tysabri, Aubagio, Tecfidera, Lemtrada, Ocrevus, or Zinbryta)?
4. What is the diagnosis or indication?
   - ☐ Relapsing remitting multiple sclerosis
   - ☐ All other diagnoses or indications (Please Specify): _____
5. What is the requested medication?
   - ☐ Aubagio (teriflunamide) – **please answer question 6**
   - ☐ Gilenya (fingolimod) – **please answer questions 7-10, 12 & 13**
   - ☐ Tecfidera (dimethyl fumarate) – **please answer question 11-13**
6. ☐ Yes ☐ No Has the patient had all of the following labs completed within the last 6 months: 1) a complete blood count (CBC), 2) liver function test (LFT), 3) bilirubin levels, 4) turberculin skin test, and 5) a negative pregnancy (if female)?
7. ☐ Yes ☐ No Has the patient had all of the following labs completed within the last 6 months: 1) a complete blood count (CBC), 2) liver function test (LFT), 3) bilirubin levels, 4) negative pregnancy (if female), 5) EKG evaluation [such as QTc GREATER THAN or EQUAL TO 500 msec, Mobitz type 2 (2nd or 3rd degree AV block)], and 6) an ophthalmic examination?
8. ☐ Yes ☐ No Does the patient have a documented history of chicken pox?
9. ☐ Yes ☐ No Has the patient had the varicella zoster vaccination OR does the patient have

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evidence of immunity (positive antibodies)?

10. ☐ Yes ☐ No Does the patient have a history of myocardial infarction (MI), unstable angina, stroke, or transient ischemic attack (TIA) within the past 6 months?
11. ☐ Yes ☐ No Has the patient had a complete blood count (CBC) completed within the last 6 months?
12. ☐ Yes ☐ No Has the patient had a trial and failure, or is contraindicated to, Aubagio?
13. ☐ Yes ☐ No Has the patient had a trial and failure, or is contraindicated to, one of the following formulary alternatives: Glatopa, Copaxone, Extavia, or Rebif?
14. ☐ Yes ☐ No Is there documentation and lab results showing that the patient is having a response to treatment with the requested medication (such as LVEF, CBC, ANC, ECG, etc.)?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851