maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Kesimpta

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the indication or diagnosis? [] Relapsing forms of multiple sclerosis (for example: clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease) (If checked, go to 2) [] Non-relapsing forms of multiple sclerosis (for example: primary progressive multiple sclerosis) (If checked, no further questions) [] Other (If checked, no further questions)		
2	Is the medication being prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis? [If no, no further questions.]	Yes	No
3	Will the patient be using the requested medication in combination with another	Yes	No

If you have any questions, call:
1-888-258-8250

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	disease-modifying agent used for multiple sclerosis [MS]? [Note: Examples include Aubagio, Avonex, Bafiertam, Betaseron, Copaxone, Extavia, Gilenya, Glatopa, Lemtrada, Mavenclad, Mayzent, Ocrevus, Plegridy, Ponvory, Rebif, Tecfidera, Tysabri, Vumerity, and Zeposia] [If yes, no further questions.]		
4	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
5	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
6	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 16.]	Yes	No
7	Has documentation been submitted to confirm that the patient has been established on therapy for at least 3 months and has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm that patient has intolerance, contraindication to, or failed treatment for at least 3 months with at least 2 preferred agents such as dimethyl fumarate, Copaxone (glatiramer acetate), Avonex (interferon beta-1a), Plegridy (peginterferon beta-1a)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Does the dose of the requested medication exceed food and drug administration (FDA) approved label dosing for the indication? [If yes, no further questions.]	Yes	No
11	Does the patient have a confirmed negative Hepatitis B infection test**?** [If no, no further questions.]	Yes	No
12	Does the patient have an active infection? [If yes, no further questions.]	Yes	No
13	Has the patient received any live or live-attenuated vaccinations 4 weeks prior; or any non-live vaccinations 2 weeks prior to initiation of the requested medication? [If yes, no further questions.]	Yes	No

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14	Does the prescriber agree to monitor immunoglobulin levels at the beginning, during, and after discontinuation of therapy? [If no, no further questions.]	Yes	No
15	Will the patient be receiving any concurrent disease modifying agents with the requested medication (including interferon beta-1a, interferon beta-1b, glatiramer acetate, or fingolimod)? [No further questions.]	Yes	No
16	Has documentation been submitted to confirm that the patient has experienced a beneficial clinical response when assessed by at least one objective measure? ACTION REQUIRED: Submit supporting documentation. [NOTE: Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions]; stabilization or reduced worsening on the Expanded Disability State Scale (EDSS) score; achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4; improvement on the fatigue symptom and impact questionnaire-relapsing multiple sclerosis (FSIQ-RMS) scale; reduction or absence of relapses; improvement or maintenance on the six-minute walk test or 12- Item MS Walking Scale; improvement on the Multiple Sclerosis Functional Composite (MSFC) score; and/or attenuation of brain volume loss.] [If yes, no further questions.]	Yes	No
17	Has documentation been submitted to confirm that the patient has experienced a stabilization, slowed progression, or improvement in at least one symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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