maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Mavenclad

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 form of multiple sclerosis. Examples of relapsing forms of multiple sclerosis include relapsing remitting disease and active secondary progressive disease (If checked, go to 2) [] Non-relapsing forms of multiple sclerosis (If checked, no further questions) [] Clinically isolated syndrome (If checked, no further questions) [] Other (If checked, no further questions)		
2	Will the requested medication be used concurrently with other disease modifying agents used for multiple sclerosis (for example, Avonex, Rebif, Betaseron, Extavia, Copaxone, Glatopa, Plegridy, Tysabri, Aubagio, Tecfidera, Lemtrada, Ocrevus, or Zinbryta)? [If yes, no further questions.]	Yes	No

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

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3	Is the requested 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
4	Is the patient currently receiving requested medication? [If no, skip to question 12.]	Yes	No
5	Does the patient have a previously approved PA on file with the current plan for the requested medication? [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 no, skip to question 12.]	Yes	No
6	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 12.]	Yes	No
7	Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? 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 no, no further questions.]	Yes	No
8	Has the patient experienced 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? [If no, no further questions.]	Yes	No
9	Has the patient been on the requested medication for 2 consecutive years? [If no, skip to question 11.]	Yes	No
10	Has the patient had a treatment break of 2 consecutive years before treatment was resumed? [If no, no further questions.]	Yes	No
11	Has documentation been submitted to confirm treatment timeline? Note: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Provider must supply documentation/approval letters with durations of approval to confirm treatment timeline. ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
12	Does the provider attest that the patient does NOT have active cancer? [If no, no further questions.]	Yes	No

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13	Is the patient of child-bearing age? [If no, skip to question 15.]	Yes	No
14	Does the provider attest that the patient of child-bearing age will use contraceptive options during treatment and up to 6 months post treatment? [If no, no further questions.]	Yes	No
15	Does the provider attest that the patient does NOT have an active chronic infection (for example, tuberculosis or hepatitis)? [If no, no further questions.]	Yes	No
16	Is the patient human immunodeficiency virus (HIV) positive? [If yes, no further questions.]	Yes	No
17	Has documentation been submitted to confirm that the patient is NOT HIV positive? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has documentation been submitted to confirm that the provider has obtained baseline lab work, within the last 3 months, that includes a complete blood count (CBC), liver function tests (LFT) and bilirubin levels? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Has documentation been submitted to confirm that the patient has adequate treatment trial and failure, at least 3 months, OR experienced an inadequate treatment response, treatment intolerance or contraindication to all of the following formulary options: a. Glatiramer; b. Extavia or Rebif; and c. Dimethyl Fumerate? 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

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.

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