PRIOR AUTHORIZATION REQUEST

ORAL MS AGENTS

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
[] Initial (If checked, go to 2)

[] Continuation (If checked, go to 15)

2 Is the patient greater than or equal to 18 year(s) of age? Yes No
[If no, no further questions.]

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

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3	Is the requested medication being prescribed by a neurologist? [If no, no further questions.]	Yes	No
4	What is the medication being requested? [] Aubagio (If checked, go to 5) [] Gilenya (If checked, go to 5) [] Mayzent (If checked, go to 5) [] Tecfidera (If checked, go to 5) [] Vumerity (If checked, go to 5) [] Ampyra (If checked, go to 26) [] Other (If checked, no further questions)		
5	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, Zinbryta)? [If yes, no further questions.]	Yes	No
6	What is the diagnosis or indication? [] Relapsing remitting multiple sclerosis (RRMS) (If checked, go to 7) [] All other diagnoses or indications (If checked, no further questions)		
7	Has the patient had a trial and failure with generic Tecfidera (dimethyl fumarate)? [If no, no further questions.]	Yes	No
8	What is the medication being requested? [] Aubagio (If checked, go to 9) [] Gilenya (If checked, go to 10) [] Mayzent (If checked, go to 10) [] Tecfidera (If checked, go to 14) [] Vumerity (If checked, go to 9)		
9	Has the patient had (1-4) 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) Tuberculin (TB) skin test, and 5) A negative pregnancy test (if female) within 1 month of starting treatment? [No further questions.]	Yes	No
10	Has the patient had (1-5) of the following labs completed within the last 6 months:	Yes	No

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	1) A complete blood count (CBC), 2) Liver function test (LFT), 3) Bilirubin levels, 4) An ophthalmic examination 5) Electrocardiogram (EKG) evaluation [such as corrected QT interval (QTc) greater than or equal to 500 msec, Mobitz type 2 (2nd or 3rd degree atrioventricular (AV) block)], and 6) A negative pregnancy test (if female) within 1 month of starting treatment? [If no, no further questions.]		
11	Does the patient have a documented history of chicken pox? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 13.]	Yes	No
12	Has the patient had the varicella zoster vaccination OR does the patient have evidence of immunity (positive antibodies)? [If no, no further questions.]	Yes	No
13	Does the patient have a history of myocardial infarction (MI), unstable angina, stroke, or transient ischemic attack (TIA) within the past 6 months? [If yes, no further questions.]	Yes	No
14	Has the patient had a complete blood count (CBC) completed within the last 6 months? [No further questions.]	Yes	No
15	What is the medication being requested? [] Aubagio (If checked, go to 16) [] Gilenya (If checked, go to 16) [] Mayzent (If checked, go to 16) [] Tecfidera (If checked, go to 16) [] Vumerity (If checked, go to 16) [] Ampyra (If checked, go to 32)		
16	Does the prescriber attest that there are records and lab results showing that the patient is having a response to treatment with the requested medication (such as left ventricular ejection fraction (LVEF), complete blood count (CBC), absolute neutrophil count (ANC), electrocardiogram (ECG), etc.)? [If no, no further questions.]	Yes	No
17	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), and 3) Bilirubin levels? [If no, no further questions.]	Yes	No
18	Has the patient received the prior authorization for this medication in the last year from Maryland Physicians Care (MPC)?	Yes	No

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	[If no, skip to question 21.]		
19	Did the patient experience intolerance, adverse side effect, or treatment failure to dimethyl fumarate (Tecfidera)? [If no, no further questions.]	Yes	No
20	Is the patient responding to therapy? [No further questions.]	Yes	No
21	What is the diagnosis or indication? [] Relapsing remitting multiple sclerosis (RRMS) (If checked, go to 22) [] All other indications (If checked, no further questions)		
22	Did the patient experience intolerance, adverse side effect, or treatment failure to dimethyl fumarate (Tecfidera)? [If no, no further questions.]	Yes	No
23	Is the patient responding to therapy? [If no, no further questions.]	Yes	No
24	Is the requested medication being prescribed by a neurologist? [If no, no further questions.]	Yes	No
25	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, Zinbryta)? [No further questions.]	Yes	No
26	Does the patient have a documented diagnosis of multiple sclerosis (MS)? [If no, no further questions.]	Yes	No
27	Is the patient wheelchair-bound? [If yes, no further questions.]	Yes	No
28	Does the patient have multiple sclerosis (MS) with ONE of the following: 1) Impaired walking ability defined as a baseline 25-ft walking test between 8 and 45 seconds OR 2) Expanded Disability Status Scale (EDSS) between 4.5 and 6.5? [If no, no further questions.]	Yes	No
29	Does the patient have a history of seizures? [If yes, no further questions.]	Yes	No
30	Does the patient have moderate to severe renal impairment (creatinine clearance [CrCl] less than 50 mL/minute)? [If yes, no further questions.]	Yes	No

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31	Is the patient stabilized on disease modifying therapy for multiple sclerosis (MS) (that is no recent MS exacerbations)? [No further questions.]	Yes	No
32	Did the patient experience at least 20% improvement in timed walking speeds on a 25-ft walk test since starting the requesting medication (within 4 weeks of starting the requested medication)?	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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