**FAX Completed Form To**
1.877.386.4695

**Provider Help Desk**
1.866.399.0928

# Request for Prior Authorization
# MULTIPLE SCLEROSIS AGENTS-ORAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

| | | |
|---|---|---|
| IA Medicaid Member ID # | Patient name | DOB |
| Patient address | | |
| Provider NPI | Prescriber name | Phone |
| Prescriber address | | Fax |
| Pharmacy name | Address | Phone |
| **Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.** | | |
| Pharmacy NPI | Pharmacy fax | NDC |

**For patients initiating therapy with a preferred oral medication, a manual prior authorization is not required if a preferred injectable interferon or non-interferon is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided:**
**1) A diagnosis of relapsing forms of multiple sclerosis, and 2) Patient meets the FDA approved age; and 3) Request is for FDA approved dosing; and 4) A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis; and 5) Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent. The required trial may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.**

**Preferred** **Non-Preferred**

☐ Aubagio ☐ Gilenya ☐ Tecfidera ☐ Mavenclad ☐ Mayzent ☐ Vumerity

| Strength | Dosage Instructions | Quantity | Days Supply |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

**Diagnosis:** _____

**Treatment failure with interferon or non-interferon:**

Trial Drug Name & Dose: _____ Trial Dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies:_____

**For patients initiating therapy with fingolimod (Gilenya):**

- Patient has a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure: ☐ Yes ☐ No

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- Patient has a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome: ☐ Yes ☐ No If yes, patient has a pacemaker: ☐ Yes ☐ No
- Patient has a baseline QTc interval ≥ 500ms: ☐ Yes ☐ No
- Patient is being treated with Class Ia or Class III anti-arrhythmic drugs: ☐ Yes ☐ No

**For patients initiating therapy with teriflunomide (Aubagio):**

- Patient has severe hepatic impairment: ☐ Yes ☐ No
- Patient has a negative pregnancy test if female of childbearing age: ☐ Yes ☐ No
  If yes, provide date of pregnancy test: _____
- If female of childbearing age, specify plan for contraception:_____
- Patient is taking leflunomide: ☐ Yes ☐ No

**For patients initiating therapy with dimethyl fumarate (Tecfidera) & diroximel fumarate (Vumerity):**

- Patient has a low lymphocyte count documented by a recent (within 6 months) CBC:
  ☐ Yes ☐ No Lab Date: _____
- For renewal, documentation of an updated CBC: Lab date: _____

**For patients initiating therapy with cladribine (Mavenclad):**

- Patient's current weight; Weight: _____ Date obtained: _____
- Does patient have a current malignancy; ☐ Yes ☐ No
- Patient is up to date on all age appropriate malignancy screening; ☐ Yes ☐ No
- Pregnancy has been excluded in females of reproductive potential: ☐ Yes ☐ No
- Women and men of reproductive potential have been advised to use contraception during treatment and for 6 months after the last dose in each treatment course; ☐ Yes ☐ No
- Women have been instructed to not breastfeed while being treated and for 10 days after the last dose:
  ☐ Yes ☐ No
- Does patient have HIV infection; ☐ Yes ☐ No
- Does patient have an active chronic infection (e.g. hepatitis or tuberculosis); ☐ Yes ☐ No
- No more than two yearly treatment courses (i.e. two treatment courses consisting of two treatment cycles) will be considered.
  Document patient's prior treatment, if applicable: _____

  _____

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**For patients initiating therapy with siponimod (Mayzent):**

- Does patient have a CYP2C9*3/*3 genotype; ☐ Yes ☐ No
- Does patient have a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III/IV heart failure; ☐ Yes ☐ No
- Does patient have a presence of Mobitz Type II 2nd degree, 3rd degree AV block or sick sinus syndrome, unless the patient has a functioning pacemaker ☐ Yes ☐ No

***Attach lab results and other documentation as necessary.***

| Prescriber signature (Must match prescriber listed above.) | Date of submission |
|---|---|
| | |

***IMPORTANT NOTE:*** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*