pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

TECFIDERA (dimethyl fumarate) [preferred] PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Tecfidera are located in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Multiple Sclerosis Agents** and **Quantity Limits/Daily Dose Limits** accessible at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:	☐Tecfidera starter pack (#1 pack = 60 capsules for 30 days, no refills) ☐Tecfidera capsule	Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		**Dx code** (*required*):	
Specialty Pharmacy Drug Program: Which specialty pharmacy will be used?		☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy	
Initial requests			
1. Does the beneficiary have a diagnosis of a relapsing form of multiple sclerosis?		☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit documentation supporting the use of Tecfidera for the beneficiary's diagnosis.*	
2. Is Tecfidera being prescribed by a neurologist?		☐Yes ☐No – prescriber specialty: _____	
3. Does the beneficiary have results of a complete blood count (CBC) with differential within the 6 months prior to initiating therapy with Tecfidera?		☐Yes ☐No	*Submit documentation of lab results.*
Renewal requests			
1. Has the beneficiary experienced improvement or stabilization of the signs and symptoms of multiple sclerosis since starting Tecfidera?		☐Yes ☐No	*Submit documentation of beneficiary's response to therapy.*
2. Does the beneficiary have results of a complete blood count (CBC) with differential 6 months after starting Tecfidera and annually thereafter?		☐Yes ☐No	*Submit documentation of lab results.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: