

RILUTEK/RILUZOLE PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Rilutek and Riluzole, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Rilutek** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- Rilutek and riluzole are subject to **quantity limits**. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to **Quantity Limits** list at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name: _____
Name of office contact: _____		Specialty: _____	
Contact's phone number: _____		State license #: _____	
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

CLINICAL INFORMATION

Medication requested:	<input type="checkbox"/> riluzole 50 mg tablet <input type="checkbox"/> Rilutek 50 mg tablet*	<i>(*If brand name is requested, submit documentation of why the Recipient cannot take the AB-rated equivalent generic.)</i>	
Dose/directions: _____		Quantity: _____	Refills: _____
Diagnosis (<i>submit documentation</i>): _____		Dx code (<i>required</i>): _____	

Section A: Initial requests

1. Does the Recipient have results of <u>baseline</u> (before starting riluzole) monitoring of a complete blood count (CBC) with differential and liver function tests (LFTs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Submit documentation of lab results.</u>
2. Is riluzole being prescribed by, or in consultation with, a neurologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Submit documentation of neurologist consultation, if applicable.</u>
3. Is the Recipient being treated for a diagnosis of amyotrophic lateral sclerosis (ALS)?	<input type="checkbox"/> Yes → <input type="checkbox"/> No →	<u>Submit documentation of diagnosis AND medical literature supporting the use of riluzole for the requested diagnosis</u>

Section B: Renewal requests

1. Has the Recipient had follow-up monitoring of a complete blood count (CBC) with differential and liver function tests (LFTs) every month for the first 3 months of therapy and every 3 months thereafter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Submit documentation of monthly lab results for the first 3 months of treatment and most recent lab results after first 3 months of treatment.</u>
2. If Recipient is being treated for a diagnosis OTHER than ALS, did the Recipient experience a positive clinical response to riluzole, such as improvement or stabilization of symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Submit documentation of Recipient's response to therapy.</u>

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

Prescriber Signature: _____	Date: _____
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