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

MULTIPLE SCLEROSIS AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Multiple Sclerosis Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of 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

Non-preferred medication requested:	☐Copaxone 40 mg ☐dalfampridine ER → use Ampyra fax form ☐Extavia ☐glatiramer acetate syringe ☐Glatopa	☐Lemtrada → use Lemtrada fax form ☐Ocrevus → use Ocrevus fax form ☐Plegridy ☐________________________ ________________________
Preferred medications that require clinical prior authorization:	☐Ampyra → use Ampyra fax form ☐Aubagio → use Aubagio fax form ☐Gilenya → use Gilenya fax form	☐Tecfidera → use Tecfidera fax form ☐Tysabri → use Tysabri fax form

Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Dx code (*required*):	

1. Multiple Sclerosis Agents are part of the DHS Specialty Pharmacy Drug Program (SPDP). Which specialty pharmacy will be used?	☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy
2. Does the beneficiary have a diagnosis of a relapsing form of multiple sclerosis?	☐Yes - *Submit documentation of diagnosis and disease pattern.* ☐No – *Submit documentation supporting the use of the requested medication for the beneficiary's diagnosis.*
3. ***For Extavia only***: Did the beneficiary experience a first clinical episode and have MRI features consistent with multiple sclerosis?	☐Yes ☐No *Submit documentation.*
4. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following preferred Multiple Sclerosis Agents? *Check all that apply.* ☐Aubagio ☐Copaxone daily 20 mg ☐Tecfidera ☐Avonex ☐Gilenya ☐Tysabri ☐Betaseron ☐Rebif	☐Yes – *Submit documentation of medication regimens tried and treatment responses, contraindications, and/or intolerances.* ☐No
5. Has the beneficiary been taking the requested non-preferred medication within the past 90 days?	☐Yes ☐No *Submit documentation of drug regimen and clinical response.*

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

Prescriber Signature:	**Date:**

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