

AUBAGIO
PRIOR AUTHORIZATION FORM

Aubagio is a Preferred agent on the Medical Assistance Preferred Drug List (PDL) & requires clinical prior authorization. To review the prior authorization guidelines, refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Multiple Sclerosis Agents: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>. Aubagio is also subject to quantity limits – if the requested quantity exceeds the limit, please submit supporting chart documentation (list of limits accessible at: <http://www.dhs.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information (PA#: _____)
pages in this request: _____ Office contact name: _____ & Phone: (_____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____
NPI#: _____ OR MA Provider ID#: _____ State License#: _____
Prescriber Address: _____ Suite #: _____
City/State/Zip: _____ Phone: (_____) _____ Fax: (_____) _____
Long-term care facility (if applicable) contact name: _____ Phone: (_____) _____

MEDICAL INFORMATION

Aubagio Dosing: 7 mg daily 14 mg daily Other: _____ **Quantity:** _____ **Refills:** _____
Diagnosis: _____ **Diagnosis Code:** _____ (required)
Physician Specialty: Neurologist Other: _____
Do any of the following apply to the Recipient (check all that apply & submit documentation)?
 Currently taking the medication leflunomide (Arava)
 Currently showing signs of an infection (e.g., fever, cold symptoms)
 Bone marrow disease or severe immunodeficiency
Specialty Pharmacy Drug Program: Which Specialty pharmacy will be used? Diplomat Specialty Pharmacy
 Walgreens Specialty Pharmacy
Female Recipients: Has Recipient undergone surgical sterilization? Yes – submit documentation No – complete (a) & (b)
(a) Does the Recipient have a recent negative pregnancy test? Yes – submit documentation No
(b) Will the Recipient be using a reliable form of contraception? Yes – submit documentation No
All Initial Requests:
1. Does the Recipient have a diagnosis of a relapsing form of Multiple Sclerosis (MS)? Yes – submit documentation No
2. Has the Recipient tried & failed any other MS agents (check all that apply & submit documentation)?
 Avonex Betaseron Copaxone Extavia Gilenya Rebif Tecfidera Tysabri Other: _____
3. Does the Recipient have contraindications or intolerances to the agents in question (2)? Yes – submit documentation No
4. Has the Recipient been screened for Tuberculosis (i.e., blood or skin testing)? Yes – submit documentation No
5. Has the Recipient had any of the following performed in the last 6 months (check all that apply & submit documentation)?
 Blood pressure monitoring CBC with Differential Liver Function Tests
All Renewal Requests:
1. Has the Recipient experienced an improvement in his/her condition and/or level of functioning?
 Yes – submit documentation No
2. Has the Recipient recently had any of the following performed (check all that apply & submit documentation)?
 Blood pressure monitoring Liver Function Tests (performed monthly for the first 6 months of therapy)

PLEASE SEND COMPLETED FORM & SUPPORTING CLINICAL INFORMATION TO DPW – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____