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

AUBAGIO (teriflunomide) [preferred] PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Aubagio 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: Aubagio tablet	Strength:	Quantity:	Refills:
Directions:			
Diagnosis *(submit documentation)*:		Dx code (*required*):	

1. 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.* ☐No – *Submit documentation supporting the use of Aubagio for the beneficiary's diagnosis.*	
3. Is the requested medication prescribed by a neurologist?	☐Yes ☐No – specialty: _____	

4. Does the beneficiary have evidence of active infection?	☐Yes	☐No	*Submit documentation.*
5. Does the beneficiary have severe hepatic impairment?	☐Yes	☐No	*Submit documentation.*
6. Is the beneficiary currently taking leflunomide (Arava)?	☐Yes	☐No	*Submit documentation.*
7. Does the beneficiary have a diagnosis of severe immunodeficiency or bone marrow disease?	☐Yes	☐No	*Submit documentation.*
8. Does the beneficiary have documentation of blood pressure monitoring, including baseline and follow-up measurements?	☐Yes	☐No	*Submit documentation.*
9. ***For females of childbearing potential***, does the beneficiary have documentation of a recent negative pregnancy test?	☐Yes	☐No	*Submit documentation.*

Initial requests

1. Does the beneficiary have results of the following? *Check all that apply and submit documentation for each.*
   - ☐recent negative PPD or blood test for tuberculosis
   - ☐CBC with differential within 6 months prior to starting Aubagio
   - ☐transaminase and bilirubin levels with ALT ≤ 2x the upper limit of normal within 6 months prior to starting Aubagio

Renewal requests

1. Has the beneficiary experienced improvement or stabilization of the signs and symptoms of multiple sclerosis since starting Aubagio?	☐Yes ☐No	*Submit documentation of beneficiary's response to therapy.*
2. Does the beneficiary have results of liver function tests (LFTs) monitored monthly for the first 6 months after starting Aubagio with ALT ≤ 3x the upper limit of normal?	☐Yes ☐No	*Submit documentation of lab results.*

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

Prescriber Signature:	**Date**: