

**GILENYA (non-preferred)
PRIOR AUTHORIZATION FORM**

To review the prior authorization guidelines for Gilenya, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Multiple Sclerosis Agents at: <http://www.dhs.state.pa.us/publications/bulletinsearch/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

Gilenya Dosing: 0.5 mg daily Other: _____ **Quantity:** _____ **Refills:** _____

Diagnosis: _____ **Diagnosis Code:** _____ (required) **Physician Type:** Neurologist Other: _____

Which Specialty Pharmacy will be utilized? Diplomat Specialty Pharmacy Walgreens Specialty Pharmacy

ALL Requests:

- Has the Recipient experienced any of the following conditions in the last 6 months (check & submit documentation)?**
 Myocardial Infarction Unstable Angina Stroke or Transient Ischemic Attack
 Decompensated Heart Failure resulting in hospitalization Class III or IV Heart Failure
- Do any of the following apply to the Recipient (check any that apply & submit documentation)?**
 Baseline QTc interval \geq 500 milliseconds Atrioventricular block without a pacemaker On an anti-arrhythmic drug
- Is the Recipient experiencing any signs of an infection (e.g., fever, cold symptoms)?** Yes – submit documentation No
- Does the Recipient have a complete listing of his/her current medications?** Yes – submit list No

All INITIAL Requests:

- Does the Recipient have a diagnosis of a relapsing form of Multiple Sclerosis (MS)?** Yes – submit documentation No
- Has the Recipient tried and failed any other MS agents (check all that apply & submit documentation)?**
 Aubagio Avonex Betaseron Copaxone Extavia Rebif Tecfidera Tysabri Other: _____
- Does the Recipient have contraindications or intolerances to any agents listed in (2)?** Yes – submit documentation No
- Has the Recipient had any of the following performed in the last 3 months (check all that apply & submit documentation)?**
 EKG Ophthalmologic exam of the macula
- Has the Recipient had any of the following performed in the last 6 months (check all that apply & submit documentation)?**
 Complete Blood Count (CBC) with Differential Liver Function Tests
- Does the Recipient have immunity to Varicella Zoster Virus (VZV), as documented by positive antibodies to VZV?**
 Yes – submit lab results No
- Has the Recipient received a VZV vaccine in the last month?** Yes – submit documentation of date No
- Will administration of the first dose of Gilenya occur in a medical facility to ensure completion of cardiac monitoring (including heart rate, blood pressure and EKG monitoring)?** Yes – submit documentation of plan No

All RENEWAL Requests – Since Gilenya was last approved, has the Recipient:

- Experienced an improvement in – or stabilization of – MS symptoms** Yes – submit documentation No
- Had any of the following performed (check all that apply & submit documentation)?**
 CBC with Differential Liver Function Tests Ophthalmologic exam of the macula*

*Perform exam 3-4 months after initiation of Gilenya; if Recipient has Diabetes or Uveitis, repeat annually thereafter

PLEASE FAX COMPLETED FORM & CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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