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

GILENYA (fingolimod) [preferred] PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Gilenya are located in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **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:	NPI:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: Gilenya capsule	**Strength:**	**Quantity:**	**Refills:**
Directions:	**Diagnosis:**		**Dx code** (*required*):

Question	Response
1. Which Specialty Pharmacy will be used?	☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy
2. Does the recipient have a diagnosis of a relapsing form of multiple sclerosis?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit documentation supporting the use of Gilenya for the recipient's diagnosis.*
3. Is the requested medication prescribed by a neurologist?	☐Yes ☐No – specialty: ____________________

Question	Response	
4. Did the recipient experience any of the following conditions in the past 6 months? ☐myocardial infarction ☐stroke or TIA ☐decompensated heart failure resulting in hospitalization ☐unstable angina ☐Class III or IV heart failure	☐Yes ☐No	*Submit documentation.*
5. Does the recipient have a baseline QTc interval ≥ 500 milliseconds?	☐Yes ☐No	*Submit documentation.*
6. Does the recipient have AV block or sick sinus syndrome without a pacemaker?	☐Yes ☐No	*Submit documentation.*
7. Is the recipient taking an anti-arrhythmic drug (eg, amiodarone, sotalol, dofetilide, quinidine)?	☐Yes ☐No	*Submit medication list.*
8. Is the recipient receiving concomitant therapy with antineoplastic, immunosuppressive, or immune modulating therapies?	☐Yes ☐No	*Submit medication list.*
9. Does the recipient have evidence of active infection?	☐Yes ☐No	*Submit documentation.*
Initial requests		
1. Does the recipient have results of a recent (within the past 6 months) CBC with differential?	☐Yes ☐No	*Submit documentation.*
2. Does the recipient have results of recent (within the past 6 months) liver function tests (LFTs)?	☐Yes ☐No	*Submit documentation.*
3. Did the recipient have an EKG in the past 3 mos with no evidence of heart block or bradycardia?	☐Yes ☐No	*Submit documentation.*
4. Did the recipient have a baseline (within past 3 months) ophthalmologic exam of the macula?	☐Yes ☐No	*Submit documentation.*
5. Does the recipient have documentation of positive antibodies to varicella zoster virus (VZV)?	☐Yes ☐No	*Submit documentation.*
6. Did the recipient receive a varicella zoster virus vaccine in the past one month?	☐Yes ☐No	*Submit documentation.*
7. Will the recipient be observed in a medical facility for at least 6 hours after the 1st dose to monitor for signs and symptoms of bradycardia as recommended in the package labeling?	☐Yes ☐No	*Submit documentation.*
8. Will the recipient have a repeat EKG performed 6 hours after the 1st dose of Gilenya?	☐Yes ☐No	*Submit documentation.*
Renewal requests		
1. Did the recipient experience improvement or stabilization of the signs and symptoms of multiple sclerosis since starting Gilenya?	☐Yes ☐No	*Submit documentation of recipient's response to therapy.*
2. Does the recipient have results of recent liver function tests (LFTs)?	☐Yes ☐No	*Submit documentation.*
3. Does the recipient have results of a recent complete blood count (CBC) with differential?	☐Yes ☐No	*Submit documentation.*
4. Did the recipient have an ophthalmologic exam of the macula 3-4 months after starting Gilenya?	☐Yes ☐No	*Submit documentation.*
5. ***For recipients with a history of diabetes or uveitis***, did the recipient have annual ophthalmologic exams of the macula (in addition to the exam performed 3-4 months after starting Gilenya)?	☐Yes ☐No ☐Not applicable	*Submit documentation.*

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

Prescriber Signature:	**Date:**

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