

RILUTEK (RILUZOLE) PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines for Rilutek (riluzole) 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 INFORMATION | | PRESCRIBER INFORMATION | |
|--------------------------------------|--|-------------------------|------------------|
| <input type="checkbox"/> New request | <input type="checkbox"/> Renewal request | total # 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

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|--|---|--|--|
| Medication requested: | <input type="checkbox"/> Rilutek tablet | <input type="checkbox"/> riluzole tablet | <input type="checkbox"/> Tiglutik suspension |
| Strength: | Dose/directions: | Quantity: | Refills: |
| Diagnosis (<i>submit documentation</i>): | | Dx code (<i>required</i>): | |

INITIAL requests

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|--|---|---|
| 1. Does the beneficiary have results of <u>baseline</u> (before starting riluzole) monitoring of a complete blood count (CBC) with differential and liver function tests (LFTs)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>Submit documentation of lab results.</i> |
| 2. Is riluzole being prescribed by, or in consultation with, a neurologist? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>Submit documentation of neurologist consultation, if applicable.</i> |
| 3. Is the beneficiary being treated for a diagnosis of amyotrophic lateral sclerosis (ALS)? | <input type="checkbox"/> Yes – <i>Submit documentation of diagnosis.</i> <input type="checkbox"/> No – <i>Submit documentation of diagnosis AND medical literature supporting the use of riluzole for the requested diagnosis.</i> | |

RENEWAL requests

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|--|---|---|
| 1. Has the beneficiary had follow-up monitoring of a complete blood count (CBC) with differential and liver function tests (LFTs) every month for the first 3 months of therapy and every 3 months thereafter? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>Submit documentation of monthly lab results for the first 3 months of treatment and most recent lab results after first 3 months of treatment.</i> |
| 2. <i>If beneficiary is being treated for a diagnosis OTHER than ALS</i> , did the beneficiary experience a positive clinical response to riluzole, such as improvement or stabilization of symptoms? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <i>Submit documentation of beneficiary's response to therapy.</i> |

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

| | |
|------------------------------|--------------|
| Prescriber Signature: | Date: |
|------------------------------|--------------|

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