

MULTIPLE SCLEROSIS AGENTS PRIOR AUTHORIZATION FORM (form effective 1/1/20)

Prior authorization guidelines for **Multiple Sclerosis Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy

Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:			Street address:	
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:		DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Beneficiary's weight:	
Directions:		Quantity:	Refills:
Diagnosis (<u>submit documentation</u>):		DX code (<u>required</u>):	
Has the beneficiary been receiving treatment with the requested medication?		<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No	
Is the beneficiary taking any other medications that interact or are contraindicated with the requested medication?		<input type="checkbox"/> Yes <i>Submit complete medication list.</i> <input type="checkbox"/> No	

INITIAL requests

For a non-preferred Multiple Sclerosis Agent: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class that are approved or medically accepted for treatment of the beneficiary's condition? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
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Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

Has a relapsing form of MS (*specify*) → clinically isolated syndrome relapsing remitting disease active secondary progressive disease
 Has primary progressive MS

Request is for AMPYRA/DALFAMPRIDINE:
 Has motor dysfunction on a continuous basis that impairs the ability to complete activities of daily living (ADLs) or instrumental ADLs
 Has results of recent kidney function tests

Request is for AUBAGIO (teriflunomide):
 Had a recent negative PPD test or blood test for tuberculosis
 Does NOT have a severe immunodeficiency, bone marrow disease, or severe uncontrolled infection
 Has results of recent liver function tests

Request is for GILENYA (fingolimod):
 Has positive antibodies to VZV, was vaccinated for VZV, or has a history of healthcare professional-confirmed chickenpox
 Did not receive a VZV vaccination in the previous 1 month
 Has a comorbid cardiac condition – describe: _____

Request is for LEMTRADA (alemtuzumab): Dates of previous treatment course(s): _____
 Had an inadequate response to 2 or more drugs indicated for the treatment of MS
 Has positive antibodies to VZV, was vaccinated for VZV, or has a history of healthcare professional-confirmed chickenpox
 Did not receive a VZV vaccination in the previous 6 weeks
 Had a recent negative PPD test or blood test for tuberculosis

Request is for MAVENCLAD (cladribine): Dates of previous treatment course(s): _____

Had an inadequate response to or cannot tolerate 1 other drug indicated for the treatment of MS

Has results of a recent lymphocyte count

Has positive antibodies to VZV, was vaccinated for VZV, or has a history of healthcare professional-confirmed chickenpox

Request is for MAYZENT (siponimod):

Has positive antibodies to VZV, was vaccinated for VZV, or has a history of healthcare professional-confirmed chickenpox

Has been tested for CYP2C9 variants to determine CYP2C9 genotype

Has a comorbid cardiac condition – describe: _____

Has any of the following:

<input type="checkbox"/> history of cardiac arrest	<input type="checkbox"/> severe untreated sleep apnea
<input type="checkbox"/> cerebrovascular disease	<input type="checkbox"/> history of recurrent syncope
<input type="checkbox"/> uncontrolled hypertension	<input type="checkbox"/> symptomatic bradycardia

Is currently taking 1 or more medications that decrease heart rate (e.g., beta blockers, diltiazem, verapamil, ivabradine, digoxin)

Prescriber consulted with a cardiologist regarding the appropriateness of treatment with Mayzent if recommended in package labeling

Request is for OCREVUS (ocrelizumab):

Does not have evidence of significant active infection

RENEWAL requests

Complete the sections below that are applicable to the beneficiary and this request and **SUBMIT DOCUMENTATION** for each item.

Request is for AMPYRA/DALFAMPRIDINE:

Experienced an improvement in motor function since starting the requested medication

Request is for AUBAGIO (teriflunomide):

Experienced improvement or stabilization of the MS disease course

Does NOT have a severe immunodeficiency, bone marrow disease, or severe uncontrolled infection

Has results of recent liver function tests

Request is for GILENYA (fingolimod):

Experienced improvement or stabilization of the MS disease course

Has a comorbid cardiac condition – describe: _____

Request is for LEMTRADA (alemtuzumab): Dates of previous treatment course: _____

Experienced improvement or stabilization of the MS disease course

Does not have signs of malignancy or autoimmune disorder

Request is for MAVENCLAD (cladribine): Dates of previous treatment course(s): _____

Experienced improvement or stabilization of the MS disease course

Has results of a recent lymphocyte count

Request is for MAYZENT (siponimod):

Experienced improvement or stabilization of the MS disease course

Has a comorbid cardiac condition – describe: _____

Has any of the following:

<input type="checkbox"/> history of cardiac arrest	<input type="checkbox"/> severe untreated sleep apnea
<input type="checkbox"/> cerebrovascular disease	<input type="checkbox"/> history of recurrent syncope
<input type="checkbox"/> uncontrolled hypertension	<input type="checkbox"/> symptomatic bradycardia

Is currently taking 1 or more medications that decrease heart rate (e.g., beta blockers, diltiazem, verapamil, ivabradine, digoxin)

Prescriber consulted with a cardiologist regarding the appropriateness of treatment with Mayzent if recommended in package labeling

Request is for OCREVUS (ocrelizumab):

Experienced improvement or stabilization of the MS disease course OR continues to benefit from Ocrevus

Does not have evidence of significant active infection

Request is for TECFIDERA (dimethyl fumarate):

Experienced improvement or stabilization of the MS disease course

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

Prescriber Signature:

Date:

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