

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Gilenya (fingolimod)
Prior Authorization of Benefits (PAB) Form
Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION
2. PHYSICIAN INFORMATION

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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3. MEDICATION
4. STRENGTH
5. DIRECTIONS
6. QUANTITY PER 30 DAYS

Gilenya (fingolimod)	_____	_____	Specify: _____
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7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Patient has a diagnosis of relapsing forms of multiple sclerosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Documentation is provided that the patient does not have a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization or Class III/IV heart failure. |
| <input type="checkbox"/> | <input type="checkbox"/> | Documentation is provided that the patient does not have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless the patient has a pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Documentation is provided that the patient does not have a baseline QTc interval greater than or equal to 500ms |
| <input type="checkbox"/> | <input type="checkbox"/> | Documentation is provided that the patient is not being treated with Class Ia or Class III anti-arrhythmic Drugs |
| <input type="checkbox"/> | <input type="checkbox"/> | Patient is 18 years of age or older |

Please Note: Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.



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Patient Name: _____ **Patient ID#:** _____

9. PHYSICIAN SIGNATURE

_____ Prescriber or Authorized Signature	_____ Date
<small><i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.</i></small> <small><i>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</i></small>	
<small>The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.</small>	