Multiple Sclerosis Agents — Oral
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
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: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA:_____
	Physician NPI #:_____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Preferred ☐ Aubagio (teriflunomide) ☐ Gilenya (fingolimod) ☐ Tecfidera (dimethyl fumarate) **Nonpreferred** ☐ Mavenclad (cladribine) ☐ Mayzent (siponimod) ☐ Vumerity (diroximel fumarate)	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

For patients initiating therapy with a preferred oral medication, a manual prior authorization is not required if a preferred injectable interferon or non-interferon is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided:

1. A diagnosis of relapsing forms of multiple sclerosis
2. Patient meets the FDA-approved age

3. Request is for FDA-approved dosing
4. A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis
5. Requests for a nonpreferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent; the required trial may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated

Treatment failure with interferon or non-interferon:
Trial drug name and dose:_____Trial dates: _____
Reason for failure: _____
Possible drug interactions/conflicting drug therapies: _____

For patients initiating therapy with fingolimod (Gilenya):
Patient has a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization or Class lll/lV heart failure:
☐ Yes ☐ No

Patient has a history or presence of Mobitz Type ll 2nd degree or 3rd degree AV block or sick sinus syndrome:
☐ Yes ☐ No
If yes, patient has a pacemaker: ☐ Yes ☐ No

Patient has a baseline QTc interval ≥ 500 ms: ☐ Yes ☐ No

Patient is being treated with Class la or Class lll anti-arrhythmic drugs: ☐ Yes ☐ No

For patients initiating therapy with teriflunomide (Aubagio):
Patient has severe hepatic impairment: ☐ Yes ☐ No

Patient has a negative pregnancy test if female of childbearing age: ☐ Yes ☐ No
If yes, provide date of pregnancy test: _____

If female of childbearing age, specify plan for contraception: _____

Patient is taking leflunomide: ☐ Yes ☐ No

For patients initiating therapy with dimethyl fumarate (Tecfidera) and diroximel fumarate (Vumerity):
Patient has a low lymphocyte count documented by a recent (within six months) CBC: ☐ Yes ☐ No
Lab date: _____

For renewal, documentation of an updated CBC: Lab date: _____

For patients initiating therapy with cladribine (Mavenclad):
Patient's current weight — Weight: _____ Date obtained: _____

Does patient have a current malignancy? ☐ Yes ☐ No

Patient is up to date on all age appropriate malignancy screening: ☐ Yes ☐ No

Pregnancy has been excluded in females of reproductive potential: ☐ Yes ☐ No

Women and men of reproductive potential have been advised to use contraception during treatment and for six months after the last dose in each treatment course: ☐ Yes ☐ No

Women have been instructed to not breastfeed while being treated and for 10 days after the last dose:
☐ Yes ☐ No

Does patient have HIV infection? ☐ Yes ☐ No

Does patient have an active chronic infection (for example, hepatitis or tuberculosis)? ☐ Yes ☐ No

No more than 2 yearly treatment courses (for example, 2 treatment courses consisting of two treatment cycles) will be considered.

Document patient's prior treatment, if applicable: _____

For patients initiating therapy with siponimod (Mayzent):
Does patient have a CYP2C9*3/*3 genotype? ☐ Yes ☐ No

Does patient have a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class lll/IV heart failure? ☐ Yes ☐ No

Does patient have a presence of Mobitz Type II 2nd degree, 3rd degree AV block or sick sinus syndrome (unless the patient has a functioning pacemaker)? ☐ Yes ☐ No

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

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.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.