Prior Authorization Request Form for Multiple Sclerosis

FAX this completed form to (844) 205-3386
OR Mail requests to: PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form:	Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	Member's weight:	
Is the member currently being treated with the requested medication?	☐Yes – date of last dose: _____ *Submit documentation.* ☐No		
Is the requested medication being prescribed by or in consultation with a neurologist (or, for Ampyra/dalfampridine, a neurologist or physical medicine and rehabilitation (PM&R) specialist)?	☐Yes ☐No	*Submit documentation of consultation if applicable.*	

Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

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

☐**Request is for a NON-PREFERRED Multiple Sclerosis Agent:**
- ☐Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class approved for the member's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐**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
- ☐Has a history of seizure

☐**Request is for AUBAGIO (teriflunomide):**
- ☐Has results of recent liver function tests

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☐ **Request is for GILENYA (fingolimod):**
- ☐ Has a comorbid heart condition – describe: _____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

☐ **Request is for KESIMPTA (ofatumumab):**
- ☐ Does not have active hepatitis B virus infection

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

☐ **Request is for MAVENCLAD (cladribine):** Dates of previous treatment course(s): _____
- ☐ Has results of a recent lymphocyte count AND:
  - ☐ Lymphocyte count is within normal limits prior to initiating first treatment course

☐ **Request is for MAYZENT (siponimod):**
- ☐ Has been tested for CYP2C9 variants to determine CYP2C9 genotype
- ☐ Has a comorbid heart condition – describe: _____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

☐ **Request is for OCREVUS (ocrelizumab):**
- ☐ Does not have active hepatitis B virus infection

☐ **Request is for ZEPOSIA (ozanimod):**
- ☐ Has severe untreated sleep apnea
- ☐ Will be taking a monoamine oxidase (MAO) inhibitor while taking Zeposia (e.g., selegiline, phenelzine)
- ☐ Has a comorbid heart condition – describe: _____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

RENEWAL requests

☐ **For AMPYRA (dalfampridine):**
- ☐ Experienced an improvement in motor function since starting the requested medication
- ☐ Has a history of seizure

☐ **For all MS drugs <u>OTHER THAN</u> Ampyra (dalfampridine):**
- ☐ Has a <u>relapsing form</u> of MS AND:
  - ☐ Experienced improvement or stabilization of the MS disease course since starting the requested medication
- ☐ Has <u>primary progressive</u> MS AND:
  - ☐ Continues to benefit from the requested medication

☐ **Request is for AUBAGIO (teriflunomide):**
- ☐ Has results of recent liver function tests

☐ **Request is for GILENYA (fingolimod):**
- ☐ Has a comorbid heart condition – describe: _____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

☐ **Request is for KESIMPTA (ofatumumab):**
- ☐ Does not have active hepatitis B virus infection

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

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

- ☐ Has results of a recent lymphocyte count AND:
  - ☐ Lymphocyte count is at least 800 cells/micoliter before initiating second treatment course

☐ **Request is for MAYZENT (siponimod):**

- ☐ Has a comorbid heart condition – describe: _____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

☐ **Request is for OCREVUS (ocrelizumab):**

- ☐ Does not have active hepatitis B virus infection

☐ **Request is for ZEPOSIA (ozanimod):**

- ☐ Has severe untreated sleep apnea
- ☐ Will be taking a monoamine oxidase (MAO) inhibitor while taking Zeposia (e.g., selegiline, phenelzine)
- ☐ Has a comorbid heart condition – describe: _____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO (844) 205-3386

Prescriber Signature:	**Date**: