# Prior Authorization Request Form for Multiple Sclerosis Agent (Not for Tysabri or Zeposia)

**FAX this completed form to (844) 205-3386**
**OR Mail requests to: Pharmacy 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/**

| I. PROVIDER INFORMATION | II. MEMBER INFORMATION |
|---|---|
| Prescriber Name: | Member Name: |
| Prescriber Specialty: | Identification #: |
| NPI: | Group #: |
| Office Contact Name: | Date of Birth: |
| Fax #: | Medication Allergies: |
| Phone #: | |

**III. DRUG INFORMATION (One drug request per form)**

| Drug name and strength: | Dosage Interval (sig): | Qty. per Day: |
|---|---|---|
| | | |

**IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)***

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

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

| | | |
|---|---|---|
| Does the member have any contraindications to the prescribed medication? | ☐ Yes<br>☐ No | *Submit documentation.* |
| **Requests for all non-preferred medications**: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Multiple Sclerosis agents? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class. **Does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred** | ☐ Yes<br>☐ No | *Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.* |

☐ If not prescribed by the following specialist, a neurologist or for Ampyra physical medicine and rehabilitation (PM&R) specialist, please indicate a specialist consulted:_____
☐ Member has a current history (within past 90 days, or if greater than 90 days dosing interval is greater than 90 days) of using the prescribed the requested non-preferred multiple sclerosis agent, since:_____
☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

***SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.***

**REQUEST FOR AMPYRA (DALFAMPRIDINE ER):**

☐ Member has motor dysfunction on a continuous basis, impairing the ability to complete instrumental activities of daily living:_____

**REQUEST FOR MAVENCLAD (CLADRIBINE):**

☐ Has documentation of recent lymphocyte count within recommended limits according to FDA-approved package labeling before initiating the first treatment course

**RENEWAL REQUESTS FOR ALL:**

- ☐ For Relapsing Form of MS, member has documented improvement or stabilizing of the multiple sclerosis disease course:_____
- ☐ For Primary Progressive MS, based on the prescriber's professional judgement, continues to benefit from the requested agent
- ☐ For Ampyra, member has improvement in motor function as evident by:_____

**RENEWAL REQUEST FOR LEMTRADA (ALEMTUZUMAB):**

- ☐ Received the previous treatment course at least 12 months prior to the requested treatment course

**RENEWAL REQUEST FOR MAVENCLAD (CLADRIBINE):**

- ☐ Member meets all the following:
  - ☐ Has documentation of recent lymphocyte count within recommended limits according to FDA-approved package labeling before initiating the first treatment course
  - ☐ Has not exceeded the recommended total number of treatment courses according to FDA-approved package labeling

## IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

| | | |
|---|---|---|
| Appropriate clinical information to support the request on the basis of medical necessity must be submitted. | Provider Signature: | Date: |

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)