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 ☐ No
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 ☐ No Medications Previously Taken (start and end date and dose):_____ [redacted]

☐ 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.)