

# MULTIPLE SCLEROSIS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

**Today's Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today's Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient's Diagnosis: <input type="checkbox"/> Relapsing-remitting disease (RRMS) <input type="checkbox"/> Active secondary progressive multiple sclerosis (SPMS) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. What is the patient's weight? _____ (kg) 2. Is the patient currently being treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? <b>Please note, chart notes are required.</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Has the patient been treated with the requested agent within the past 90 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain risk: _____ _____ 4. Does this request include a loading dose? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____ _____ 5. Did the patient receive the starter pack through any means (e.g., manufacturer supplied)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient requesting for initial maintenance dose?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ _____ 7. Is the prescriber a specialist in the area of the patient's diagnosis (i.e., neurologist) or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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8. Is the patient's age within FDA labeling for the requested indication for the requested agent? .....  Yes  No  
 If no, please give support for using the requested agent for the patient's age for the requested indication: \_\_\_\_\_

9. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For Mavenclad requests:**

10. Has the patient been previously treated with the requested agent?.....  Yes  No  
 If yes, how many courses has the patient completed (one course consists of 2 cycles of 4-5 days each)? \_\_\_\_\_

11. Has a complete CBC with differential including lymphocyte count been performed? .....  Yes  No

12. Is the lymphocyte count within normal limits?.....  Yes  No

13. Will the patient be using the requested agent in combination with an additional disease modifying agent (DMA) for the requested indication? .....  Yes  No  
 If yes, please provide support for the use of the additional DMA (e.g., relapse between cycles): \_\_\_\_\_  
 \_\_\_\_\_

14. Can the requested quantity (dose) be achieved with a lower quantity of packs and a higher pack size (e.g., two 10 tablet packs instead of four 5 tablet packs)?.....  Yes  No  
 If no, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**For Aubagio requests:**

15. Has the prescriber obtained transaminase and bilirubin levels within 6 months prior to initiating treatment?.....  Yes  No

**For Gilenya or Tascenso ODT requests:**

16. Has the prescriber performed an electrocardiogram within 6 months prior to initiating treatment?.....  Yes  No

**For Aubagio, Bafiertam, Copaxone, Gilenya 0.5 mg, or Tecfidera requests:**

**Please use the following table to answer the following questions, and please submit chart notes to support the answers:**

Non-Preferred Agents	Corresponding generic
Aubagio	teriflunomide
Copaxone	Glatopa/glatiramer
Gilenya 0.5 mg	fingolimod
Bafiertam, Tecfidera	dimethyl fumarate

17. Does the patient have an intolerance or hypersensitivity to the corresponding generic that is not expected to occur with the requested agent? .....  Yes  No

18. Does the patient have an FDA labeled contraindication to the corresponding generic agent that is not expected to occur with the requested agent? .....  Yes  No

19. Was the corresponding generic discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

20. Is the corresponding generic expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm?.....  Yes  No

21. Is the corresponding generic not in the best interest of the patient based on medical necessity? .....  Yes  No

22. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the corresponding generic and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

23. Is there support for using the requested agent over the corresponding generic?.....  Yes  No  
 If yes, please provide supporting information: \_\_\_\_\_  
 \_\_\_\_\_

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For Aubagio, Bafiertam, Copaxone, Extavia, Gilenya, Ponvory, Tascenso ODT, or Tecfidera requests:**

24. Will the patient be using the requested agent in combination with an additional disease modifying agent (DMA) for the requested indication? .....  Yes  No  
 If yes, will the requested agent be used in combination with Mavenclad (cladribine)?.....  Yes  No  
 If yes, please give rationale in support for using the requested agent in combination with Mavenclad (e.g., relapse between cycles of Mavenclad): \_\_\_\_\_

25. Does the patient have a diagnosis of a relapsing form of MS? .....  Yes  No

**Please submit chart notes to support the answers to the following questions:**

26. Has the patient been treated with at least 3 MS agents from different drug classes? .....  Yes  No  
 27. Does the patient have highly active MS disease activity? .....  Yes  No  
 If yes, has the patient had greater than or equal to 2 relapses in the previous year? .....  Yes  No  
 If yes, does the patient have greater than or equal to 1 gadolinium enhancing lesion on MRI? .....  Yes  No  
 If yes, does the patient have significant increase in T2 lesion load compared with a previous MRI? .....  Yes  No

**Please use the following table to answer the following questions, and please submit chart notes to support the answers:**

Preferred Agent(s)	Non-Preferred Agent(s)
<b>Avonex</b> (interferon β-1a)	<b>Aubagio</b> (teriflunomide)
<b>Betaseron</b> (interferon β-1b)	<b>Bafiertam</b> (monomethyl fumarate)
dimethyl fumarate	<b>Copaxone</b> (glatiramer)
fingolimod	<b>Extavia</b> (interferon β-1b)
glatiramer	<b>Gilenya</b> (fingolimod)
<b>Glatopa</b> (glatiramer)	<b>Ponvory</b> (ponesimod)
<b>Kesimpta</b> (ofatumumab)	<b>Tascenso ODT</b> (fingolimod)
<b>Mavenclad</b> (cladribine)	<b>Tecfidera</b> (dimethyl fumarate)
<b>Mayzent</b> (siponimod)	
<b>Plegridy</b> (peginterferon β-1a)	
<b>Rebif</b> (interferon β-1a)	
teriflunomide	
<b>Vumerity</b> (diroximel fumarate)	
<b>Zeposia</b> (ozanimod)	

28. Has the patient tried and had an inadequate response to TWO preferred agents that are FDA labeled for the treatment of the requested indication? .....  Yes  No  
 29. Were TWO preferred agents FDA labeled for the treatment of the requested indication discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No  
 30. Does the patient have an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to TWO preferred agents FDA labeled for the treatment of the requested indication? .....  Yes  No  
 31. Does the patient have an FDA labeled contraindication to ALL preferred agents FDA labeled for the treatment of the requested indication? .....  Yes  No  
 32. Are TWO preferred agents FDA labeled for the treatment of the requested indication expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? .....  Yes  No  
 33. Are TWO preferred agents FDA labeled for the treatment of the requested indication not in the best interest of the patient based on medical necessity? .....  Yes  No  
 34. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as TWO preferred agents FDA labeled for the treatment of the requested indication and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

**Please continue to the next page.**

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**For Tascenso ODT 0.5mg requests OR requests for patients 17 years of age or younger:**

**Please submit chart notes to support the answers to the following questions:**

35. Has the patient tried and had an inadequate response to generic fingolimod? .....  Yes  No
36. Was generic fingolimod discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
37. Does the patient have an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to generic fingolimod? .....  Yes  No
38. Does the patient have an FDA labeled contraindication to generic fingolimod? .....  Yes  No
39. Is generic fingolimod expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? .....  Yes  No
40. Is generic fingolimod not in the best interest of the patient based on medical necessity? .....  Yes  No
41. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic fingolimod and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
42. Is there support for the use of the requested agent over generic fingolimod (e.g., swallowing difficulties)? .....  Yes  No  
 If yes, please provide supporting information: \_\_\_\_\_

**For all renewal requests:**

43. Has the patient had clinical benefit with the requested agent? .....  Yes  No

**For Mavenclad renewal requests:**

44. How many courses has the patient completed (one course consists of 2 cycles of 4-5 days each)? \_\_\_\_\_
45. Does the patient have a lymphocyte count of at least 800 cells/ $\mu$ L? .....  Yes  No
46. Has it been at least 35 weeks but not more than 67 weeks since the last dose of the requested agent? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
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