



Request for Prior Authorization
MULTIPLE SCLEROSIS AGENTS-ORAL

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

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.

- 1) A diagnosis of relapsing forms of multiple sclerosis, and 2) Patient meets the FDA approved age; and 3) A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis; and 4) Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent.

Preferred

- Aubagio, Gilenya, Tecfidera

Strength, Dosage Instructions, Quantity, Days Supply

Diagnosis:

Treatment failure with interferon or non-interferon:

Trial Drug Name & 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 III/IV heart failure: Yes No

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- Patient has a history or presence of Mobitz Type II 2<sup>nd</sup> degree or 3<sup>rd</sup> degree AV block or sick sinus syndrome:  Yes  No If yes, patient has a pacemaker:  Yes  No
- Patient has a baseline QTc interval  $\geq$  500ms:  Yes  No
- Patient is being treated with Class Ia or Class III 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):**

- Patient has a low lymphocyte count documented by a recent (within 6 months) CBC:  
 Yes  No Lab Date: \_\_\_\_\_
- For renewal, documentation of an updated CBC: Lab date: \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.