



Request for Prior Authorization

FAX Completed Form To

1 (800) 574-2515

MULTIPLE SCLEROSIS AGENTS-ORAL

Provider Help Desk

1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>		
Pharmacy NPI	Pharmacy fax	NDC

For patients initiating therapy with a preferred oral multiple sclerosis agent, a manual prior authorization (PA) 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. If a preferred injectable agent is not found in the member’s pharmacy claims, documentation of the following must be provided:

1. A diagnosis of relapsing forms of multiple sclerosis, and
2. Request must adhere to all FDA approved labeling, including indication, age, dosing, contraindications, and warnings and precautions; and
3. Documentation of a previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis.

Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent.

The required trial may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred

Non-Preferred

- |  |                                  |                                    |                                       |                                    |
|--|----------------------------------|------------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Aubagio           | <input type="checkbox"/> Gilenya | <input type="checkbox"/> Bafiertam | <input type="checkbox"/> Mayzent      | <input type="checkbox"/> Tecfidera |
| <input type="checkbox"/> Dimethyl Fumarate |                                  | <input type="checkbox"/> Kesimpta  | <input type="checkbox"/> Ponvory      | <input type="checkbox"/> Vumerity  |
|  |                                  | <input type="checkbox"/> Mavenclad | <input type="checkbox"/> Tascenso ODT | <input type="checkbox"/> Zeposia   |

<b>Strength</b>	<b>Dosage Instructions</b>	<b>Quantity</b>	<b>Days Supply</b>
_____	_____	_____	_____

Diagnosis: \_\_\_\_\_

Treatment failure with a preferred interferon or non-interferon:

Trial Drug Name & Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Reason for failure: \_\_\_\_\_

Possible drug interactions/conflicting drug therapies: \_\_\_\_\_

Requests for non-preferred oral multiple sclerosis agents:

Document trial of preferred oral multiple sclerosis agent:

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**MULTIPLE SCLEROSIS AGENTS-ORAL**

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Drug Name & Dose \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure Reason \_\_\_\_\_

**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.*