HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

MULTIPLE SCLEROSIS AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines for **Multiple Sclerosis Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form:	Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	Beneficiary's weight:	
Is the beneficiary currently being treated with the requested medication?	☐Yes – date of last dose: _____ *Submit documentation.* ☐No		
Is the requested medication being prescribed by or in consultation with a neurologist (or, for Ampyra/dalfampridine, a neurologist or physical medicine and rehabilitation (PM&R) specialist)?	☐Yes ☐No	*Submit documentation of consultation if applicable.*	

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

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

☐**Request is for a NON-PREFERRED Multiple Sclerosis Agent:**
- ☐Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class approved for the beneficiary's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐**Request is for AMPYRA (dalfampridine):**
- ☐Has motor dysfunction on a continuous basis that impairs the ability to complete activities of daily living (ADLs) or instrumental ADLs
- ☐Has results of recent kidney function tests
- ☐Has a history of seizure

☐**Request is for AUBAGIO (teriflunomide):**
- ☐Has results of recent liver function tests

☐**Request is for GILENYA (fingolimod):**

☐ Has a comorbid heart condition – describe: _____
☐ Experienced any of the following in the past 6 months:
- ☐ Myocardial infarction
- ☐ Unstable angina
- ☐ Stroke
- ☐ Transient ischemic attack
- ☐ Decompensated heart failure requiring hospitalization
- ☐ Class III or IV heart failure

☐ **Request is for KESIMPTA (ofatumumab):**
☐ Does not have active hepatitis B virus infection

☐ **Request is for LEMTRADA (alemtuzumab):** Dates of previous treatment course(s): _____

☐ **Request is for MAVENCLAD (cladribine):** Dates of previous treatment course(s): _____
☐ Has results of a recent lymphocyte count AND:
☐ Lymphocyte count is within normal limits prior to initiating first treatment course

☐ **Request is for MAYZENT (siponimod):**
☐ Has been tested for CYP2C9 variants to determine CYP2C9 genotype
☐ Has a comorbid heart condition – describe: _____
☐ Experienced any of the following in the past 6 months:
- ☐ Myocardial infarction
- ☐ Unstable angina
- ☐ Stroke
- ☐ Transient ischemic attack
- ☐ Decompensated heart failure requiring hospitalization
- ☐ Class III or IV heart failure

☐ **Request is for OCREVUS (ocrelizumab):**
☐ Does not have active hepatitis B virus infection

☐ **Request is for ZEPOSIA (ozanimod):**
☐ Has severe untreated sleep apnea
☐ Will be taking a monoamine oxidase (MAO) inhibitor while taking Zeposia (e.g., selegiline, phenelzine)
☐ Has a comorbid heart condition – describe: _____
☐ Experienced any of the following in the past 6 months:
- ☐ Myocardial infarction
- ☐ Unstable angina
- ☐ Stroke
- ☐ Transient ischemic attack
- ☐ Decompensated heart failure requiring hospitalization
- ☐ Class III or IV heart failure

RENEWAL requests

☐ **For AMPYRA (dalfampridine):**
☐ Experienced an improvement in motor function since starting the requested medication
☐ Has a history of seizure

☐ **For all MS drugs <u>OTHER THAN</u> Ampyra (dalfampridine):**
☐ Has a <u>relapsing form</u> of MS AND:
☐ Experienced improvement or stabilization of the MS disease course since starting the requested medication
☐ Has <u>primary progressive</u> MS AND:
☐ Continues to benefit from the requested medication

☐ **Request is for AUBAGIO (teriflunomide):**
☐ Has results of recent liver function tests

☐ **Request is for GILENYA (fingolimod):**
☐ Has a comorbid heart condition – describe: _____
☐ Experienced any of the following in the past 6 months:
- ☐ Myocardial infarction
- ☐ Unstable angina
- ☐ Stroke
- ☐ Transient ischemic attack
- ☐ Decompensated heart failure requiring hospitalization
- ☐ Class III or IV heart failure

☐ **Request is for KESIMPTA (ofatumumab):**

☐ Does not have active hepatitis B virus infection

☐ **Request is for LEMTRADA (alemtuzumab):** Dates of previous treatment course(s): _____

☐ **Request is for MAVENCLAD (cladribine):** Dates of previous treatment course(s): _____

☐ Has results of a recent lymphocyte count AND:

☐ Lymphocyte count is at least 800 cells/micoliter before initiating second treatment course

☐ **Request is for MAYZENT (siponimod):**

☐ Has a comorbid heart condition – describe: _____

☐ Experienced any of the following in the past 6 months:

☐ Myocardial infarction
☐ Unstable angina
☐ Stroke
☐ Transient ischemic attack
☐ Decompensated heart failure requiring hospitalization
☐ Class III or IV heart failure

☐ **Request is for OCREVUS (ocrelizumab):**

☐ Does not have active hepatitis B virus infection

☐ **Request is for ZEPOSIA (ozanimod):**

☐ Has severe untreated sleep apnea

☐ Will be taking a monoamine oxidase (MAO) inhibitor while taking Zeposia (e.g., selegiline, phenelzine)

☐ Has a comorbid heart condition – describe: _____

☐ Experienced any of the following in the past 6 months:

☐ Myocardial infarction
☐ Unstable angina
☐ Stroke
☐ Transient ischemic attack
☐ Decompensated heart failure requiring hospitalization
☐ Class III or IV heart failure

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: