

PRIOR AUTHORIZATION REQUEST FORM

MULTIPLE SCLEROSIS AGENTS

Aubagio®, Avonex®, Bafiertam™, Betaseron®, Copaxone®, Extavia®, Gilenya®, Glatopa®, H.P. Acthar Gel®, Kesimpta®, Lemtrada®, Mavenclad®, Mayzent®, Ocrevus®, Plegridy®, Ponvory®, Rebif®, Rituxan®, Tecfidera®, Tysabri®, Vumerity®, Zeposia®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to 801-213-1547.
- For **Retail Pharmacy** requests please fax requests to: 888-509-8142

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: Aubagio® (teriflunomide), Betaseron® (interferon beta-1a), dimethyl fumarate*, Gilenya® (fingolimod), glatiramer acetate*, Kesimpta® (ofatumumab), Mayzent® (siponimod), Ocrevus® (ocelizumab), Rebif® (interferon beta-1a), preferred rituximab products, Tysabri® (natalizumab)

* dimethyl fumarate and glatiramer acetate do not require prior authorization

Non-Preferred with a Single Step (trial and failure of at least 1 preferred agent): Mavenclad® (cladribine)

Non-Preferred: Lemtrada® (alemtuzumab), Ponvory® (ponesimod), Zeposia® (ozanimod)

Non-Formulary: Avonex® (interferon beta-1a), Bafiertam™ (monomethyl fumarate), Copaxone® (glatiramer acetate), Extavia® (interferon beta-1a), Glatopa® (glatiramer acetate), Plegridy® (peginterferon beta-1a), Tecfidera® (dimethyl fumarate), Vumerity® (diroximel fumarate)

H.P. Acthar Gel® (repository corticotropin injection): may not be considered for coverage for the treatment of MS unless clinical documentation shows at least a 3-month trial and failure or contraindication to all preferred and non-preferred agents taken at the maximum-tolerated, FDA-approved dose.

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of Multiple Sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the prescriber a neurologist or working in consultation with a neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	
RITUXAN®			
1. Is the request for a preferred rituximab product? If yes, no other questions required.	<input type="checkbox"/>	<input type="checkbox"/>	
OCREVUS®			
1. Has the member trialed and failed Tysabri® or at least two of the following? <ul style="list-style-type: none"> • Aubagio® • Rebif®, or Betaseron® • dimethyl fumarate • Gilenya® or Mayzent® • glatiramer acetate • Kesimpta® • a preferred rituximab product 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
TYSABRI®			
<ul style="list-style-type: none"> • Has the member trialed and failed Ocrevus® or at least two of the following? • Aubagio® • Rebif® or Betaseron® • dimethyl fumarate • Gilenya® or Mayzent® • glatiramer acetate • Kesimpta® • a preferred rituximab product 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
NON-PREFERRED AGENTS			
1. If a non-preferred medication is being requested, have <i>all</i> preferred products been trialed, with the exception of rituximab?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated with a neurologist within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be effective with evidence of a positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member show a continued medical need for therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			

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Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request. ****

Policy: PHARM-044
Origination Date: 10/26/2016
Reviewed/Revised Date: 08/24/2022
Next Review Date: 08/24/2023
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