HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

MULTIPLE SCLEROSIS AGENTS

Aubagio®, Avonex®, Bafiertam™, Betaseron®, Briumvi®, 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 Healthy U Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- For **Retail Pharmacy** please fax requests to: 385-425-4052

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 Pharmacy Customer Service for assistance at 385-425-5094

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: ☐ Betaseron® (interferon beta-1a), ☐ dimethyl fumarate*, ☐ fingolimod*, ☐ glatiramer acetate*, ☐ Rebif® (interferon beta-1a), ☐ Preferred rituximab products*, ☐ teriflunomide
* do not require prior authorization

Preferred with a Single Step (trial and failure dimethyl fumarate, fingolimod, or a rituximab biosimilar OR a contraindication to all THREE): ☐ Briumvi® (ublituximab), ☐ Kesimpta® (ofatumumab), ☐ Mayzent® (siponimod), ☐Ocrevus® (ocrelizumab), ☐ Tysabri® (natalizumab)

Non-Formulary: ☐ Aubagio® (teriflunomide), ☐ Avonex® (interferon beta-1a), ☐ Bafiertam™ (monomethyl fumarate), ☐ Copaxone® (glatiramer acetate), ☐ Extavia® (interferon beta-1a), ☐ Gilenya® (fingolimod), ☐ Glatopa® (glatiramer acetate), H.P. Acthar Gel® (repository corticotropin injection): ☐ Lemtrada® (alemtuzumab), ☐ Mavenclad® (cladribine), ☐ Plegridy® (peginterferon beta-1a), ☐ Ponvory® (ponesimod), ☐ Tecfidera® (dimethyl fumarate), ☐ Vumerity® (diroximel fumarate), ☐ Zeposia® (ozanimod)

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?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	

3. Is the prescriber a neurologist or working in consultation with a neurologist?	☐	☐	
H.P. ACTHAR GEL®			
1. Has the member tried or has a contraindication to all preferred and non-preferred agents taken at the maximum-tolerated FDA approved dose for at least 3 months each?	☐	☐	**Please provide documentation**
OCREVUS®			
1. Does the member have a diagnosis of primary progressive multiple sclerosis?	☐	☐	**Please provide documentation**
H.P. Acthar Gel®			
• Has the member trialed and failed all preferred and non-preferred agents?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated with a neurologist within the past 12 months?	☐	☐	
3. Has the therapy shown to be effective with evidence of a positive clinical response?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for therapy?	☐	☐	**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:			
Physician's Signature:			

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

Policy PHARM-HU-044
Origination Date: 01/01/2022
Reviewed/Revised Date:11/08/2023
Next Review Date: 11/08/2024
Current Effective Date: 12/01/2023