REALRx

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 Real Rx at 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 assistance 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), ☐ Briumvi® (ublituximab), ☐ dimethyl fumarate*, ☐ fingolimod, ☐ glatiramer acetate*, ☐ Kesimpta® (ofatumumab), ☐ Mayzent® (siponimod), ☐ Ocrevus® (ocelizumab), ☐ Rebif® (interferon beta-1a), ☐ preferred rituximab products, ☐ teriflunomide, ☐ Tysabri® (natalizumab)
* dimethyl fumarate and glatiramer acetate 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: ☐ Aubagio® (teriflunomide), ☐ Avonex® (interferon beta-1a), ☐ Bafiertam™ (monomethyl fumarate), ☐ Copaxone® (glatiramer acetate), ☐ Extavia® (interferon beta-1a), ☐ Gilenya® (fingolimod), ☐ 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. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐	
2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time	☐	☐	

frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.			
3. Does the member have a diagnosis of Multiple Sclerosis?	☐	☐	**Please provide documentation**
4. Is the member 18 years of age or older?	☐	☐	
5. Is the prescriber a neurologist or working in consultation with a neurologist?	☐	☐	
RITUXAN®			
1. Is the request for a preferred rituximab product? If yes, no other questions required.	☐	☐	
BRIUMVI® AND OCREVUS®			
1. Has the member trialed and failed Tysabri® or at least two of the following? • Aubagio® • Rebif®, or Betaseron® • dimethyl fumarate • Gilenya® or Mayzent® • glatiramer acetate • Kesimpta® • a preferred rituximab product	☐	☐	**Please provide documentation**
TYSABRI®			
1. Has the member trialed and failed Briumvi® or Ocrevus® or at least two of the following? • Aubagio® • Rebif® or Betaseron® • dimethyl fumarate • Gilenya® or Mayzent® • glatiramer acetate • Kesimpta® • a preferred rituximab product	☐	☐	**Please provide documentation**
NON-PREFERRED AGENTS			
1. If a non-preferred medication is being requested, have *all* preferred products been trialed, with the exception of rituximab?	☐	☐	**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-044
Origination Date: 10/26/2016
Reviewed/Revised Date: 11/08/2023
Next Review Date: 11/08/2024
Current Effective Date: 12/01/2023