

**TECFIDERA**  
**PRIOR AUTHORIZATION FORM**

Tecfidera is a Preferred agent on the Medical Assistance Preferred Drug List (PDL) & requires clinical prior authorization. To review the prior authorization guidelines, refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Multiple Sclerosis Agents: <http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm>.

**PRIOR AUTHORIZATION REQUEST INFORMATION**

New       Renewal       Additional Information (PA#: \_\_\_\_\_)  
# pages in this request: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_ Phone:(\_\_\_\_\_) \_\_\_\_\_

**RECIPIENT INFORMATION**

Name: \_\_\_\_\_ Recipient ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
NPI#: \_\_\_\_\_ OR MA Provider ID#: \_\_\_\_\_ State License#: \_\_\_\_\_  
Prescriber Address: \_\_\_\_\_ Suite #: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Phone:(\_\_\_\_\_) \_\_\_\_\_ Fax:(\_\_\_\_\_) \_\_\_\_\_  
Long-term care facility (if applicable) contact name & phone: \_\_\_\_\_

**MEDICAL INFORMATION**

**Tecfidera Dosing:**  120 mg BID       240 mg BID       Other: \_\_\_\_\_  
**Quantity:** \_\_\_\_\_ **Refills:** \_\_\_\_\_  
**Diagnosis:** \_\_\_\_\_ **Diagnosis Code:** \_\_\_\_\_ (required)  
**Physician Specialty:**  Neurologist       Other: \_\_\_\_\_  
**Specialty Pharmacy Drug Program:** Which Specialty pharmacy will be used?  
 Diplomat Specialty Pharmacy       Walgreens Specialty Pharmacy

**Initial Requests:**

1. Does the Recipient have a diagnosis of a relapsing form of Multiple Sclerosis (MS)?  
 Yes – submit documentation       No
2. Does the Recipient have labwork results for a Complete Blood Count with Differential from the past 6 months?  
 Yes – submit documentation       No

**Renewal Requests:**

1. Since Tecfidera was last approved, has the Recipient experienced an improvement in – or stabilization of – MS symptoms?  Yes – submit documentation       No
2. Does the Recipient have follow-up labwork results for a Complete Blood Count with Differential?  
 Yes – submit documentation       No

PLEASE **FAX** COMPLETED FORM WITH CLINICAL INFORMATION TO DPW – PHARMACY DIVISION

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_