

MULTIPLE SCLEROSIS AGENTS PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Multiple Sclerosis Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Multiple Sclerosis Agents** and **Quantity Limits/Daily Dose Limits** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	# of pages in request: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested*:	<input type="checkbox"/> Copaxone <u>40 mg</u> <input type="checkbox"/> Extavia	<input type="checkbox"/> Glatopa <input type="checkbox"/> Plegridy
<p>*The following medication is non-preferred and has a <u>drug-specific fax form</u>: Gilenya (Gilenya fax form). Please call the Pharmacy Services help desk for requests for Lemtrada.</p>		
<p><i>The following medications are <u>preferred</u> or not included on the PDL and require <u>clinical prior authorization</u> using <u>drug-specific fax forms</u>: Ampyra (Ampyra fax form), Aubagio (Aubagio fax form), Tecfidera (Tecfidera fax form), Tysabri (Tysabri fax form).</i></p>		
Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):	
1. Does the Recipient have a diagnosis of a relapsing form of multiple sclerosis?	<input type="checkbox"/> Yes - <u>submit documentation of diagnosis and disease pattern.</u> <input type="checkbox"/> No – <u>submit documentation supporting the use of the requested medication for the Recipient's diagnosis.</u>	
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following preferred Multiple Sclerosis Agents? <i>Check all that apply.</i>	<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and therapeutic failure.</u> <input type="checkbox"/> No	
<input type="checkbox"/> Ampyra <input type="checkbox"/> Betaseron <input type="checkbox"/> Rebif <input type="checkbox"/> Aubagio <input type="checkbox"/> Copaxone <u>20 mg</u> <input type="checkbox"/> Tecfidera <input type="checkbox"/> Avonex		

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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