



Request for Prior Authorization
MULTIPLE SCLEROSIS AGENTS-ORAL

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Prior authorization is required for fingolimod (Gilenya™), teriflunomide (Aubagio®), or dimethyl fumarate (Tecfidera™). Payment will be considered for patients 18 years of age or older under the following conditions: 1) A diagnosis of relapsing forms of multiple sclerosis, and 2) A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis. The required trial may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

- Checkboxes for Aubagio®, Gilenya™, and Tecfidera™.

Strength Dosage Instructions Quantity Days Supply

\_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment failure with interferon or non-interferon:

Trial Drug Name & Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Reason for failure: \_\_\_\_\_

Possible drug interactions/conflicting drug therapies: \_\_\_\_\_

For patients initiating therapy with fingolimod (Gilenya™), please document the following:

- Patient has a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure: [ ] Yes [ ] No
• Patient has a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome: [ ] Yes [ ] No If yes, patient has a pacemaker: [ ] Yes [ ] No
• Patient has a baseline QTc interval ≥ 500ms: [ ] Yes [ ] No
• Patient is being treated with Class Ia or Class III anti-arrhythmic drugs: [ ] Yes [ ] No

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**For patients initiating therapy with teriflunomide (Aubagio®), please document the following:**

- Patient has severe hepatic impairment:  Yes  No
- Patient has a negative pregnancy test if female of childbearing age:  Yes  No  
If yes, provide date of pregnancy test: \_\_\_\_\_
- If female of childbearing age, specify plan for contraception: \_\_\_\_\_
- Patient is taking leflunomide:  Yes  No

**For patients initiating therapy with dimethyl fumarate (Tecfidera™), please document the following:**

- Patient has a low lymphocyte count documented by a recent (within 6 months) CBC:  
 Yes  No Lab Date: \_\_\_\_\_
- For renewal, documentation of an updated CBC: Lab date: \_\_\_\_\_

***Attach lab results and other documentation as necessary.***

Prescriber signature (Must match prescriber listed above.)	Date of submission
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***IMPORTANT NOTE:*** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.