MULTIPLE SCLEROSIS AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Multiple Sclerosis Agents** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	# of pages: ________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form:	Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code *(required)*:	Member's weight:	
Is the member currently being treated with the requested medication?	☐Yes – date of last dose: ______________ *Submit documentation.* ☐No		
Is the requested medication being prescribed by or in consultation with a neurologist (or, for Ampyra/dalfampridine, a neurologist or physical medicine and rehabilitation (PM&R) specialist)?	☐Yes ☐No	*Submit documentation of consultation if applicable.*	

Complete all sections that apply to the member and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

☐Has a relapsing form of MS *(specify)* → ☐clinically isolated syndrome ☐relapsing remitting disease ☐active secondary progressive disease

☐Has primary progressive MS

☐**Request is for a NON-PREFERRED Multiple Sclerosis Agent:**

- ☐Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class approved for the member's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐**Request is for AMPYRA (dalfampridine):**

- ☐Has motor dysfunction on a continuous basis that impairs the ability to complete activities of daily living (ADLs) or instrumental ADLs
- ☐Has results of recent kidney function tests
- ☐Has a history of seizure

☐**Request is for AUBAGIO (teriflunomide):**

- ☐Has results of recent liver function tests

- ☐ **Request is for BRIUMVI (ublituximab):**
  - ☐ Does not have active hepatitis B virus infection
- ☐ **Request is for GILENYA (fingolimod):**
  - ☐ Has a comorbid heart condition – describe: ______________________________
  - ☐ Experienced any of the following in the past 6 months:
    - ☐ Myocardial infarction
    - ☐ Unstable angina
    - ☐ Stroke
    - ☐ Transient ischemic attack
    - ☐ Decompensated heart failure requiring hospitalization
    - ☐ Class III or IV heart failure
- ☐ **Request is for KESIMPTA (ofatumumab):**
  - ☐ Does not have active hepatitis B virus infection
- ☐ **Request is for LEMTRADA (alemtuzumab):** Dates of previous treatment course(s): ______________________________
- ☐ **Request is for MAVENCLAD (cladribine):** Dates of previous treatment course(s): ______________________________
  - ☐ Has results of a recent lymphocyte count AND:
    - ☐ Lymphocyte count is within normal limits prior to initiating first treatment course
- ☐ **Request is for MAYZENT (siponimod):**
  - ☐ Has been tested for CYP2C9 variants to determine CYP2C9 genotype
  - ☐ Has a comorbid heart condition – describe: ______________________________
  - ☐ Experienced any of the following in the past 6 months:
    - ☐ Myocardial infarction
    - ☐ Unstable angina
    - ☐ Stroke
    - ☐ Transient ischemic attack
    - ☐ Decompensated heart failure requiring hospitalization
    - ☐ Class III or IV heart failure
- ☐ **Request is for OCREVUS (ocrelizumab):**
  - ☐ Does not have active hepatitis B virus infection
- ☐ **Request is for ZEPOSIA (ozanimod):**
  - ☐ Has severe untreated sleep apnea
  - ☐ Will be taking a monoamine oxidase (MAO) inhibitor while taking Zeposia (e.g., selegiline, phenelzine)
  - ☐ Has a comorbid heart condition – describe: ______________________________
  - ☐ Experienced any of the following in the past 6 months:
    - ☐ Myocardial infarction
    - ☐ Unstable angina
    - ☐ Stroke
    - ☐ Transient ischemic attack
    - ☐ Decompensated heart failure requiring hospitalization
    - ☐ Class III or IV heart failure

RENEWAL requests

- ☐ **For AMPYRA (dalfampridine):**
  - ☐ Experienced an improvement in motor function since starting the requested medication
  - ☐ Has a history of seizure
- ☐ **For all MS drugs OTHER THAN Ampyra (dalfampridine):**
  - ☐ Has a relapsing form of MS AND:
    - ☐ Experienced improvement or stabilization of the MS disease course since starting the requested medication
  - ☐ Has primary progressive MS AND:
    - ☐ Continues to benefit from the requested medication
- ☐ **Request is for AUBAGIO (teriflunomide):**
  - ☐ Has results of recent liver function tests
- ☐ **Request is for BRIUMVI (ublituximab):**
  - ☐ Does not have active hepatitis B virus infection

pa health & wellness

☐ **Request is for GILENYA (fingolimod):**
- ☐ Has a comorbid heart condition – describe: ______________________________
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

☐ **Request is for KESIMPTA (ofatumumab):**
- ☐ Does not have active hepatitis B virus infection

☐ **Request is for LEMTRADA (alemtuzumab):** Dates of previous treatment course(s): ______________________________

☐ **Request is for MAVENCLAD (cladribine):** Dates of previous treatment course(s): ______________________________
- ☐ Has results of a recent lymphocyte count AND:
  - ☐ Lymphocyte count is at least 800 cells/micoliter before initiating second treatment course

☐ **Request is for MAYZENT (siponimod):**
- ☐ Has a comorbid heart condition – describe:

  ____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

☐ **Request is for OCREVUS (ocrelizumab):**
- ☐ Does not have active hepatitis B virus infection

☐ **Request is for ZEPOSIA (ozanimod):**
- ☐ Has severe untreated sleep apnea
- ☐ Will be taking a monoamine oxidase (MAO) inhibitor while taking Zeposia (e.g., selegiline, phenelzine)
- ☐ Has a comorbid heart condition – describe:

  ____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
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  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date:**

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Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)