Iowa Department of Human Services

Request for Prior Authorization
MULTIPLE SCLEROSIS AGENTS-ORAL

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

For patients initiating therapy with a preferred oral medication, a manual prior authorization is not required if a preferred injectable interferon or non-interferon is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided:
1) A diagnosis of relapsing forms of multiple sclerosis, and 2) Patient meets the FDA approved age; and 3) A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis; and 4) Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent. The required trial may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred

☐ Aubagio ☐ Gilenya ☐ 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):

- 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

Request for Prior Authorization
MULTIPLE SCLEROSIS AGENTS-ORAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

- 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

For patients initiating therapy with teriflunomide (Aubagio):

- 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):

- 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

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.*