mercy care

Fax completed prior authorization request form to 855-247-3677 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/rbha-forproviders/pharmacy

Multiple Sclerosis (MS) Agents
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
Preferred Agents:	☐ **Copaxone 20mg**	☐ **Betaseron**	☐ **Avonex**
	☐ **Gilenya**	☐ **Glatopa 40mg**	☐ **Rebif / Rebidose**

Non-Preferred Agent:	Other, Please Specify:		
	Was there inadequate response, intolerable side effects OR contraindication to 2 formulary agents, one of which was an interferon or glatiramer acetate?	☐ Yes	☐ No

Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No	ICD-10 Code:	Diagnosis:

What medication(s) have been tried and failed for the diagnosis?

Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ Initial request	☐ Continuation of therapy

☐ CONTINUATION of therapy requests ONLY:

Was documentation AND lab results submitted supporting response to TX AND no serious toxicity as result of TX?	☐ Yes	☐ No	Are the required initial therapy tests completed AND continuously monitored as clinically appropriate? (LVEF, CBC, ANC, ECG, immunoglobulins level, contraception use for females of reproductive potential)	☐ Yes	☐ No

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information		
Have other disease modifying MS therapies (not including Ampyra) been D/C'd OR have been D/C'd?	☐ Yes	☐ No

INJECTABLE AGENTS				
☐ Copaxone 40mg	☐ Avonex	☐ Glatopa 20mg glatiramer acetate	☐ Extavia	☐ Rebif/Rebidose

Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No

☐ Betaseron			☐ Plegridy				
Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No		
ORAL AGENTS							
☐ Aubagio							
Is diagnosis clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No		
Is member FEMALE of reproductive potential?	☐ Yes	☐ No	Is FEMALE member pregnant?	☐ Yes	☐ No	☐ N/A	
Will FEMALE member be using effective contraception during treatment?				☐ Yes	☐ No	☐ N/A	
The following LABS have been completed within last SIX months:	☐ CBC	☐ LFTs and bilirubin	☐ Tuberculin skin test				
☐ Bafiertam							
Is the diagnosis relapsing form of MS (for example, relapsing-remitting or active secondary progressive MS)?				☐ Yes	☐ No		
Does member have clinically isolated syndrome suggestive of MS (for example, experienced 1st clinical episode and MRI features consistent with MS)?				☐ Yes	☐ No		
Was baseline (within 3 months) MRI scan obtained prior to starting TX course due to risk of PML?				☐ Yes	☐ No		
Is there history of either varicella vaccine series OR zoster vaccine series if 50 years of age or older?				☐ Yes	☐ No		
The following labs have been completed within past 6 months:	☐ CBC and lymphocyte count		☐ LFTs and bilirubin levels				
☐ Gilenya							
Is diagnosis clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No		
Labs have been completed within past 6 months:	☐ CBC	☐ LFTs and bilirubin	☐ ECG	☐ Ophthalmic examination			
Is there history of either varicella vaccine series OR zoster vaccine series if 50 years of age or older?				☐ Yes	☐ No		
Documented history of ANY of the following:	☐ MI - Unstable Angina – stroke – TIA - Decompensated HF requiring hospitalization OR Class III/IV HF within past 6 months						
	☐ Corrected QTc ≥500 msec						
	☐ HX of Mobitz type II (2nd OR 3rd degree AV block) OR sick sinus syndrome, unless there is a pacemaker						
	☐ Treatment with Class Ia OR Class III anti-arrhythmic drugs						
☐ Mayzent							
Is diagnosis clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No		
Was member tested for CYP2C9 variants to determine CYP2C9 genotype?	☐ Yes	☐ No	Is member positive for CYP2C9*3/*3?	☐ Yes	☐ No		
Labs have been completed within past 6 months:	☐ CBC	☐ LFTs and bilirubin	☐ ECG	☐ Ophthalmic exam			
Is there history of either varicella vaccine series OR zoster vaccine series if 50 years of age or older?				☐ Yes	☐ No		
Documented history of ANY of the following:	☐ MI - Unstable Angina – Stroke – TIA - Decompensated HF requiring hospitalization OR Class III/IV HF within past SIX months						
	☐ History of Mobitz type II (2nd OR 3rd degree AV block) OR sick sinus syndrome, unless member has pacemaker						
☐ Mavenclad							
Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No		
Was baseline (within 3 months) MRI scan obtained prior to starting TX course due to risk of PML?	☐ Yes	☐ No	Is there infection with HIV AND active chronic infections (Hepatitis OR TB) OR breastfeeding (during TX OR for 10 days after last dose)?	☐ Yes	☐ No		
Is member a FEMALE of reproductive potential?	☐ Yes	☐ No	Is the FEMALE member pregnant?	☐ Yes	☐ No	☐ N/A	

Will the FEMALE member be using effective contraception during treatment?	☐ Yes	☐ No	☐ N/A
Has the member received the lifetime maximum of 2 courses (4 cycles) of therapy?	☐ Yes	☐ No	

☐ Zeposia

Is the diagnosis of relapsing form of MS (for ex relapsing-remitting or active secondary progressive MS)?	☐ Yes	☐ No	
Is there clinically isolated syndrome suggestive of MS (for example experienced a 1st clinical episode and have MRI features consistent with MS?	☐ Yes	☐ No	

Any ONE of the following is present:	☐ History (within last 6 months) of MI, UA, stroke, TIA, decompensated heart failure requiring hospitalization OR NYHA Class III/IV heart failure
	☐ History OR presence of Mobitz Type II 2nd OR 3rd degree AV block, sick sinus syndrome OR sino-atrial block (unless there is a functioning pacemaker)
	☐ Severe untreated sleep apnea

ALL the following labs were completed within the last 6 months:	☐ CBC	☐ LFTs and bilirubin levels
	☐ ECG	☐ Ophthalmic examination

Is there HX of either varicella vaccine series OR zoster vaccine series if 50 years of age or older?	☐ Yes	☐ No
Was baseline (past 3 months) MRI scan obtained prior to starting TX course due to risk of PML?	☐ Yes	☐ No

Is member a FEMALE of reproductive potential?	☐ Yes	☐ No	Is the FEMALE member pregnant?	☐ Yes	☐ No	☐ N/A
Will the FEMALE member be using effective contraception during treatment?				☐ Yes	☐ No	☐ N/A

☐ Tecfidera ☐ Vumerity

Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
The following LABS have been completed within last SIX months:			☐ CBC	☐ LFTs and bilirubin	

INFUSIONS

☐ Ocrevus

Was member screened for Hepatitis B?	☐ Yes	☐ No	Does member have active Hepatitis B infection?	☐ Yes	☐ No
Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
Is diagnosis of Primary-Progressive MS?	☐ Yes	☐ No			

☐ Lemtrada

Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No	Will treatment exceed FIVE days the first year, AND THREE days the 2nd year?	☐ Yes	☐ No
Is the member infected with HIV?	☐ Yes	☐ No			

The following been completed prior to starting TX?	☐ CBC	☐ Necessary immunizations	☐ Serum creatinine levels
	☐ History of either varicella vaccine series OR zoster vaccine series if 50 years of age or older		
	☐ Screened for TB AND If screening positive, TX was received	☐ Thyroid Function Test	

☐ Tysabri

Is diagnosis clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND MRI features consistent w/MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
Has anti-JCV antibody test (ELISA [enzyme-linked immunosorbent assay]) been completed?				☐ Yes	☐ No

☐ Mitoxantrone

Member has ANY of the following MS diagnosis:	☐ Worsening relapsing-remitting to reduce neurologic disability AND/OR frequency of clinical relapse	☐ Secondary (chronic) progressive	☐ Progressive relapsing	☐ Primary progressive

Was cumulative lifetime dose exceeded?	☐ Yes	☐ No

The following labs have been completed within last SIX months:	☐ LVEF >50% (not below lower limit of normal)	☐ ANC >1500 cells/mm3
	☐ CBC	☐ LFTs

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.
Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-564-5465 to check the status of a request.