pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

MULTIPLE SCLEROSIS AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines for **Multiple Sclerosis Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐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:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form:	Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	Beneficiary's weight:	
Is the beneficiary 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 beneficiary 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 beneficiary'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 GILENYA (fingolimod):
- ☐Has a comorbid heart condition – describe: _____

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☐ 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 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

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☐ 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
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

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

Prescriber Signature:	Date: