Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Multiple Sclerosis Agents Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Multiple Sclerosis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the requested medication listed as preferred on the most current Pharmacy Preferred Drug List? ❑ **Yes** ❑ **No**

If **no**, answer the following based on the request:

Injectable Agents

Has the recipient experienced therapeutic failure of at least one different preferred medication within the same drug class (or the brand/generic formulation of the requested agent, if applicable)? ❑ **Yes** ❑ **No**

Has the recipient had an allergy, contraindication, drug-to-drug interaction, or a history of unacceptable/toxic side effects with ALL preferred medications within the same drug class? ❑ **Yes** ❑ **No**

Is the non-preferred medication being requested because it is being used for a unique indication that is supported by peer-reviewed literature or an FDA-approved indication? ❑ **Yes** ❑ **No**

Oral Agents

Has the recipient experienced therapeutic failure of at least two different preferred medications within the same drug class (including the brand/generic formulation of the requested agent, if applicable)? ❑ **Yes** ❑ **No**

Has the recipient had an allergy, contraindication, drug-to-drug interaction, or a history of unacceptable/toxic side effects with ALL preferred medications within the same drug class? ❑ **Yes** ❑ **No**

Is the non-preferred medication being requested because it is being used for a unique indication that is supported by peer-reviewed literature or an FDA-approved indication? ❑ **Yes** ❑ **No**

List any medications that were tried and failed for the given diagnosis as documented above:

Drug Name	Reason for Failure	Date(s)

Drug-Specific Information (required)

Ampyra® (dalfampridine)

Is the medication being used to improve the recipient's walking speed? ❑ **Yes** ❑ **No**

Is the medication prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

Is the recipient ambulatory and has an EDSS score between 2.5 and 6.5? ❑ **Yes** ❑ **No**

Does the recipient have moderate to severe renal dysfunction (CrCL ≤50 ml/min)? ❑ **Yes** ❑ **No**

Does the recipient have a history of seizures? ❑ **Yes** ❑ **No**

Is the recipient currently pregnant or attempting to conceive? ❑ **Yes** ❑ **No**

Is the request for initial authorization or continuation of therapy? ❑ **Initial Authorization** ❑ **Continuation of Therapy**

Lemtrada® (alemtuzumab)

Does the recipient have a diagnosis of a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses)? ❑ **Yes** ❑ **No**

Will the medication be used in combination with another disease-modifying therapy for MS? ❑ **Yes** ❑ **No**

Has the recipient been previously treated with alemtuzumab? ❑ **Yes** ❑ **No**

If **yes,** has at least 12 months elapsed or will at least 12 months have elapsed since the most recent treatment course with alemtuzumab? ❑ **Yes** ❑ **No**

If **no**, has recipient had failure after a trial of at least four weeks, a contraindication, or an intolerance to <u>two</u> of the following disease-modifying therapies for MS? ❑ **Yes** ❑ **No**

- Aubagio® (teriflunomide)
- Avonex® (interferon beta-1a)
- Betaseron® (interferon beta-1b)
- Copaxone®/Glatopa® (glatiramer acetate)
- Extavia® (interferon beta-1b)
- Gilenya® (fingolimod)
- Mavenclad® (cladribine)
- Mayzent® (siponimod)
- Ocrevus® (ocrelizumab)
- Plegridy® (peginterferon beta-1a)
- Rebif® (interferon beta-1a)
- Tecfidera® (dimethyl fumarate)
- Tysabri® (natalizumab)

Mavenclad® (cladribine)

Does the recipient have a diagnosis of a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses)? ❑ **Yes** ❑ **No**

Will the medication be used in combination with another disease-modifying therapy for MS? ❑ **Yes** ❑ **No**

Has the recipient been previously treated with cladribine? ❑ **Yes** ❑ **No**

If **yes,** has the recipient already received the FDA-recommended lifetime limit of two treatment courses (or four treatment cycles total) of cladribine? ❑ **Yes** ❑ **No**

If **no**, has recipient had failure after a trial of at least four weeks, a contraindication, or an intolerance to <u>two</u> of the following disease-modifying therapies for MS? ❑ **Yes** ❑ **No**

- Aubagio® (teriflunomide)
- Avonex® (interferon beta-1a)
- Betaseron® (interferon beta-1b)
- Copaxone®/Glatopa® (glatiramer acetate)
- Extavia® (interferon beta-1b)
- Gilenya® (fingolimod)
- Lemtrada® (alemtuzumab)
- Mayzent® (siponimod)
- Ocrevus® (ocrelizumab)
- Plegridy® (peginterferon beta-1a)
- Rebif® (interferon beta-1a)
- Tecfidera® (dimethyl fumarate)
- Tysabri® (natalizumab)

Ocrevus® (ocrelizumab)

Does the recipient have a diagnosis of a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses)? ❑ **Yes** ❑ **No**

Does the recipient have a diagnosis of Primary Progressive Forms of Multiple Sclerosis (PPMS)? ❑ **Yes** ❑ **No**

Will the medication be used in combination with another disease-modifying therapy for MS? ❑ **Yes** ❑ **No**

Will the medication be used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan®], belimumab [Benlysta®], ofatumumab [Arzerra®])? ❑ **Yes** ❑ **No**

Will the medication be used in combination with another lymphocyte trafficking blocker (e.g., alemtuzumab [Lemtrada®], mitoxantrone)? ❑ **Yes** ❑ **No**

Is this a recertification request for Ocrevus®? ❑ **Yes** ❑ **No**

If **yes**, is there documentation of a positive clinical response to Ocrevus® therapy? ❑ **Yes** ❑ **No**

Please attach all supporting documentation to request

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.