AmeriHealth Caritas
Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Multiple Sclerosis Agents-Oral

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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:

Prior authorization is required for fingolimod (Gilenya™), teriflunomide (Aubagio®), or dimethyl fumarate (Tecfidera™). Payment will be considered for patients 18 years of age or older under the following conditions: 1) A diagnosis of relapsing forms of multiple sclerosis, and 2) A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis; and 3) 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.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult **www.iowamedicaidpdl.com/pa_criteria**.

Preferred:

☐ Gilenya™

Non-Preferred:

☐ Aubagio®

☐ Tecfidera™

Strength: Quantity: Days supply:

Dosage instructions:

Diagnosis:

Treatment failure with interferon or non-interferon:

Trial drug name and dose: Trial dates:

Failure reason:

Possible drug interactions/conflicting drug therapies:

For patients initiating therapy with fingolimod (Gilenya™), 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:

- Patient has a recent (within past six months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure: ☐ No ☐ Yes
- Patient has a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome: ☐ No ☐ Yes
  If yes, patient has a pacemaker: ☐ No ☐ Yes
- Patient has a baseline QTc interval ≥ 500ms: ☐ No ☐ Yes
- Patient is being treated with Class Ia or Class III anti-arrhythmic drugs: ☐ No ☐ Yes

For patients initiating therapy with teriflunomide (Aubagio®), please document the following:

- Patient has severe hepatic impairment: ☐ No ☐ Yes
- Patient has a negative pregnancy test if female of childbearing age: ☐ No ☐ Yes
  If yes, provide date of pregnancy test:
- If female of childbearing age, specify plan for contraception:
- Patient is taking leflunomide: ☐ No ☐ Yes
- **Gilenya Trial:** Dose: Trial dates:

  Failure reason:

For patients initiating therapy with dimethyl fumarate (Tecfidera™), please document the following:

- Patient has a low lymphocyte count documented by a recent (within 6 months) CBC: ☐ No ☐ Yes

  Lab date:
- **Gilenya Trial:** Dose: Trial dates:

  Failure Reason:
- For renewal, documentation of an updated CBC: Lab Date:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
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.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.