CareFirst Family of health care plans

CVS caremark™

Multiple Sclerosis
Prior Authorization Request

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the member identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

PATIENT INFORMATION
Date: _____
Name: _____
ID: _____
Date of Birth: _____
Request Initiated For: _____
_____

PRESCRIBER INFORMATION
Name: _____
Office Telephone: _____
Office Fax: _____
Specialty: _____
NPI#:

DRUG PRESCRIBED

❑ Ampyra 40mg	❑ Aubagio	❑ Avonex	❑ Betaseron	❑ Copaxone 20mg	❑ Copaxone
❑ Extavia	❑ Gilenya	❑ Glatopa	❑ Lemtrada	❑ Plegridy	❑ Rebif
❑ Tecfidera	❑ Tysabri	❑ Zinbryta	❑ Other _____		

PATIENT DIAGNOSIS & ICD-10 CODE
❑ Relapsing form of multiple sclerosis
❑ First clinical episode of multiple sclerosis
❑ Primary progressive multiple sclerosis (PPMS)
❑ Other
_____

ICD-10: _____

DRUG SPECIFIC QUESTIONS - ***Please note that more than one section may need to be completed.***

AVONEX, EXTAVIA, PLEGRIDY OR ZINBRYTA

1. Is the prescriber willing to switch to one of the Preferred Formulary Product(s) (i.e., Betaseron, Rebif, Copaxone, Gilenya, Tecfidera or Aubagio)? ❑ Yes ❑ No
   If Yes, indicate product and no further questions: _____
2. Has the patient received at least a 28-day supply of the requested medication within the previous 120 days in a paid claim through a pharmacy or medical benefit? ❑ Yes ❑ No
   If Yes, indicate start date and PA number (if applicable):
   _____
3. Indicate if patient has tried and had an inadequate response, intolerance/confirmed adverse event **or** has a contraindication to any Preferred Formulary Product(s) (i.e., Betaseron, Rebif, Copaxone, Gilenya, Tecfidera or Aubagio).
   A) Drug: _____ ❑ Patient has not tried any Preferred Formulary Product(s)
   Outcome:
   ❑ Inadequate response, ***indicate trial duration:***
   _____
   ❑ Intolerance/confirmed adverse event(s), ***indicate:***
   _____

❑ Contraindication(s), ***indicate:***
_____

B) Drug: _____
Outcome:
❑ Inadequate response, ***indicate trial duration:***
_____
❑ Intolerance/confirmed adverse event(s), ***indicate:***
_____
❑ Contraindication(s), ***indicate:***
_____

AMPYRA
1. Is this request for continuation of therapy with Ampyra? ❑ Yes ❑ No *If No, skip to #4*
2. Is the patient receiving Ampyra through samples or a manufacturer's patient assistance program? *If Yes, skip to #4* ❑ Yes ❑ No
3. Has the patient experienced improvement in walking speed or another objective measure of walking ability since starting Ampyra? ❑ Yes ❑ No *No further questions*
4. Prior to beginning Ampyra, does/did the patient have sustained walking impairment? ❑ Yes ❑ No

LEMTRADA
1. How many courses of Lemtrada treatment has the patient received during his/her lifetime? _____ courses
2. Has the patient had an inadequate response to two or more drugs indicated for MS? ❑ Yes ❑ No

ZINBRYTA
1. Has the patient had an inadequate response to two or more drugs indicated for MS? ❑ Yes ❑ No

AUTHORIZATION
I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**