

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

PATIENT DIAGNOSIS & ICD-10 CODE

Relapsing form of multiple sclerosis Primary progressive multiple sclerosis (PPMS)
 First clinical episode of multiple sclerosis Other

ICD-10: _____

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

AVONEX, EXTAVIA, PLEGRIDY OR ZINBRYTA

- 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: _____
- 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):

- 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:*

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Multiple Sclerosis PDPD SGM - 4/2017.

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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)