aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-799-2551 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at
www.aetnabetterhealth.com/michigan/providers/medicaid/pharmacy

Multiple Sclerosis Agents
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
☐ **Aubagio®**	☐ **Bafiertam™**	☐ **Copaxone® 40 mg**	☐ **Glatiramer 20mg/ml and 40 mg/ml**
☐ **Gilenya®**	☐ **Glatopa®**	☐ **Mavenclad®**	☐ **Mayzent®**
☐ **Plegridy®**	☐ **Ponvory®**	☐ **Rebif®/ Rebif Rebidose®**	☐ **Tascenso ODT®**
☐ **Tecfidera®**	☐ **Vumerity®**	☐ **Zeposia®**	☐ **Other, please specify:**

Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	ICD-10 Code:	Diagnosis:
What medication(s) have been tried and failed for diagnosis? (please specify):		
Has the member had a therapeutic failure after one-month trial with two preferred medications?	☐ Yes	☐ No
Does the member have any of the following to the preferred medication(s): (check all that apply)	☐ Allergy ☐ Contraindication or drug interactions ☐ History of unacceptable side effects	

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.

	Signature: _____

Bafiertam			
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)?		☐ Yes	☐ No
Prescriber attests that Bafiertam will be used as single agent monotherapy		☐ Yes	☐ No
RENEWAL of Bafiertam:	☐ Attestation of tolerance to maintenance dose	☐ Attestation of a CBC, including lymphocyte count, serum aminotransferase, ALP, and total bilirubin levels	

Plegridy, Mavenclad, Mayzent, Vumerity, Zeposia		
Has the member had a therapeutic failure of one-month trial of at least two preferred medications?	☐ Yes	☐ No

Ponvory			
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)?		☐ Yes	☐ No
☐ Member has obtained a baseline electrocardiogram (ECG)	☐ Prescriber attests that first-dose monitoring, as clinically indicated, will occur	☐ Member does NOT have an active infection, including clinically important localized infections	☐ Member has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy
For members with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment?		☐ Yes	☐ No
Prescriber attests that ponesimod will NOT be used in combination with anti-neoplastic, immunosuppressive, or immune-modulating therapies, or, if therapy is unavoidable, the member will be monitored closely for adverse reactions and/or dose modifications?		☐ Yes	☐ No
Has the member had a therapeutic failure of one-month trial of at least two preferred medications?		☐ Yes	☐ No

Mavenclad		
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include relapsing-remitting disease and active secondary progressive disease?	☐ Yes	☐ No

Mayzent			
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)?		☐ Yes	☐ No
☐ Member CYP2C9 variant status has been tested to determine genotyping (required for dosing)	☐ Member has obtained a baseline electrocardiogram (ECG)	☐ Member has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy	☐ Members with a history of uveitis and/or diabetes ONLY; a baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment

Tascenso ODT		
Does the member have a diagnosis of a relapsing form of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) or active secondary progressive disease (SPMS)?	☐ Yes	☐ No
Is the member unable to use generic fingolimod capsules or brand Gilenya capsules due to swallowing difficulties?	☐ Yes	☐ No

Vumerity		
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)?	☐ Yes	☐ No

Zeposia		
Does the member have a diagnosis of moderately or severely active ulcerative colitis (UC) and is prescribed by or in consultation with a gastroenterologist?	☐ Yes	☐ No
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)?	☐ Yes	☐ No

☐ Member has obtained a baseline electrocardiogram (ECG)	☐ Member does NOT have an active infection, including clinically important localized infections	☐ Member has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning	☐ Members with a history of uveitis and/or diabetes ONLY; a baseline ophthalmic evaluation of the fundus, including the macula, before starting

		therapy	treatment

Prescriber attests that a CBC with lymphocyte count, ALT, AST, and total bilirubin have been obtained for the member in the past 6 months?	☐ Yes	☐ No
For MS, has the member had a therapeutic failure of one-month trial of at least two preferred medications?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 855-300-5528 to check the status of a request.