

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR MULTIPLE SCLEROSIS (MS) AGENTS, IMMUNOMODULATORS**

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators Completion Instructions, F-00805A. Providers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators form signed by the prescriber before submitting a PA request on the Portal, by fax, or by mail. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION (Required for all PA requests.)

13. Diagnosis Code and Description

14. List the member's current MS immunomodulator therapy or check "none" if appropriate.

None

Drug Name _____ Daily Dose _____ Start Date _____

Drug Name _____ Daily Dose _____ Start Date _____

Continued



SECTION III — CLINICAL INFORMATION (Required for all PA requests.) (Continued)

15. List the member's previous MS immunomodulator therapy and reason(s) for discontinuation or check "none" if appropriate.

None

Drug Name _____ Daily Dose _____ Dates Taken _____

Reason for Discontinuation _____

Drug Name _____ Daily Dose _____ Dates Taken _____

Reason for Discontinuation _____

Drug Name _____ Daily Dose _____ Dates Taken _____

Reason for Discontinuation _____

SECTION IV — CLINICAL INFORMATION FOR NON-PREFERRED ORAL MS IMMUNOMODULATORS

16. Prior authorization requests must include detailed documentation regarding why the member is unable to take or has previously discontinued both Aubagio treatment and Gilenya treatment. Medical records must be provided to support the need for a non-preferred oral agent. The following will **not** be considered as criteria to support the need for a non-preferred oral agent:

- Non-adherence to previous MS treatment.
- Member or prescriber preference for the use of a non-preferred oral agent.

1. Aubagio Documentation

2. Gilenya Documentation

SECTION V — CLINICAL INFORMATION FOR MS INTERFERONS

17. Prior authorization requests for non-preferred MS interferons must include detailed documentation regarding why the member has previously discontinued **at least two** preferred MS interferon treatments. Medical records must be provided to support the need for a non-preferred MS interferon. The following will **not** be considered as criteria to support the need for a non-preferred MS interferon:

- Non-adherence to previous MS treatment.
- Member or prescriber preference for the use of a non-preferred MS interferon.
- Member or prescriber preference for a less frequent dosing schedule.

1. Preferred MS Interferon Documentation

2. Preferred MS Interferon Documentation

SECTION VI — AUTHORIZED SIGNATURE

18. SIGNATURE — Prescriber

19. Date Signed

SECTION VII — ADDITIONAL INFORMATION

20. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.
