

**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](http://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.

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**SECTION I — MEMBER INFORMATION**

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

2. Member Identification Number

3. Date of Birth — Member

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**SECTION II — PRESCRIPTION INFORMATION**

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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

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

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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*



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

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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 \_\_\_\_\_

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

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16. Prior authorization requests must include detailed documentation regarding why the member is unable to take or has previously discontinued Copaxone® treatment *and* MS interferon 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.
- The member's fear of needles.
- Member or prescriber preference for the use of an oral agent.

Copaxone® Documentation

MS Interferon Documentation

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**SECTION V — CLINICAL INFORMATION FOR COPAXONE® 40 MG**

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17. Prior authorization requests for Copaxone® 40 mg must include detailed documentation regarding why the member is unable to take or has previously discontinued Copaxone® 20 mg treatment. Medical records must be provided to support the need for Copaxone® 40 mg. The following will *not* be considered as criteria to support the need for Copaxone® 40 mg:
- Non-adherence to previous MS treatment.
  - Member or prescriber preference for the use of an oral agent.

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**SECTION VI — AUTHORIZED SIGNATURE**

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18. SIGNATURE — Prescriber

19. Date Signed

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**SECTION VII — ADDITIONAL INFORMATION**

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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.
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