DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00805 (07/2017)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

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 ID 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

Continued

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 – CLINICAL INFORMATION FOR ZINBRYTA®

18. Prior authorization requests for Zinbryta® must include detailed documentation regarding why the member has previously discontinued a preferred agent from at least two of the following – Aubagio®, Gilenya®, preferred MS Interferons, and Copaxone®. Medical records must be provided to support the need for Zinbryta®. The following will **not** be considered as criteria to support the need for Zinbryta®:
    - Non-adherence to previous MS treatment
    - Member or prescriber preference for the use of Zinbryta®
    - Member or prescriber preference for a less frequent dosing schedule

    1. Preferred MS Immunomodulator Agent Documentation

    2. Preferred MS Immunomodulator Agent Documentation

Continued

SECTION VII – CLINICAL INFORMATION FOR GLATOPA®

19. Prior authorization requests for Glatopa® must include detailed clinical justification for prescribing Glatopa® instead of the preferred agents, Copaxone® 20 mg and Copaxone® 40 mg. This clinical information must document why the member cannot use Copaxone® 20 mg and Copaxone® 40 mg, including why it is medically necessary that the member receive Glatopa® instead of Copaxone® 20 mg and Copaxone® 40 mg.

SECTION VIII – AUTHORIZED SIGNATURE

20. **SIGNATURE** – Prescriber	21. Date Signed

SECTION IX – ADDITIONAL INFORMATION

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

Reset Form