DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00805 (07/2018)

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 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. Phone 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. PA 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:
    - Nonadherence 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. PA 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:
    - Nonadherence 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 GLATOPA

18. PA 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 VII – AUTHORIZED SIGNATURE

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

SECTION VIII – ADDITIONAL INFORMATION

21. 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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