DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00805 (07/2020)

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

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR MULTIPLE SCLEROSIS (MS) AGENTS, IMMUNOMODULATORS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Multiple Sclerosis (MS) Agents, Immunomodulators Instructions, F-00805A. Providers may refer to the Forms page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Multiple Sclerosis (MS) Agents, Immunomodulators form signed by the prescriber before submitting a prior authorization 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 _____

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

❑ None

Drug Name _____ Daily Dose _____ Date(s) Taken _____

Reason for Discontinuation _____

Drug Name _____ Daily Dose _____ Date(s) Taken _____

Reason for Discontinuation _____

Drug Name _____ Daily Dose _____ Date(s) Taken _____

Reason for Discontinuation _____

SECTION IV – CLINICAL INFORMATION FOR NON-PREFERRED ORAL MS AGENTS, IMMUNOMODULATORS (ORAL AGENTS)

16. PA requests must include detailed documentation regarding why the member is unable to take or has previously discontinued Aubagio treatment, Gilenya treatment, and Tecfidera treatment. **Medical records must be provided** to support the need for the requested 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

3. Tecfidera Documentation

SECTION V – CLINICAL INFORMATION FOR NON-PREFERRED INTERFERONS, MS AGENTS, IMMUNOMODULATORS (INTERFERON AGENTS)

17. PA requests for non-preferred interferon agents must include detailed documentation regarding why the member has previously discontinued **at least two** preferred interferon agent treatments. **Medical records must be provided** to support the need for the requested non-preferred interferon agent. The following will **not** be considered as criteria to support the need for a non-preferred interferon agent:
    - Nonadherence to previous MS treatment
    - Member or prescriber preference for the use of a non-preferred interferon agent
    - Member or prescriber preference for a less frequent dosing schedule

    1. Preferred Interferon Agent Documentation

    2. Preferred Interferon Agent 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.

Reset Form