

**FORWARDHEALTH  
PRIOR AUTHORIZATION DRUG ATTACHMENT  
FOR MULTIPLE SCLEROSIS (MS) AGENTS**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Multiple Sclerosis (MS) Agents Instructions, F-00805A. Prescribers 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 form signed and dated by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Prescribers and pharmacy 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 ID 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. Address – Prescriber (Street, City, State, Zip + 4 Code)

11. Phone Number – Prescriber

12. National Provider Identifier – 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 agents therapy or check "None" if appropriate.

None

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Start Date \_\_\_\_\_

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Start Date \_\_\_\_\_

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15. List the member's previous MS agents therapy and the 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 AGENTS (ORAL AGENTS)**

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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 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

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## **SECTION V – CLINICAL INFORMATION FOR KESIMPTA**

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17. PA requests must include detailed documentation regarding why the member is unable to take or has previously discontinued Gilenya treatment and Tecfidera treatment. **Medical records must be provided** to support the need for Kesimpta. The following will **not** be considered as criteria to support the need for Kesimpta:

- Nonadherence to previous MS treatment
- Member or prescriber preference for the use of Kesimpta

1. Gilenya Documentation

2. Tecfidera Documentation

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## **SECTION VI – CLINICAL INFORMATION FOR NON-PREFERRED INTERFERONS, MS AGENTS (INTERFERONS)**

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

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

1. Preferred Interferon Documentation

2. Preferred Interferon Documentation

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## **SECTION VII – CLINICAL INFORMATION FOR GLATOPA**

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19. PA requests for Glatopa must include detailed clinical justification for prescribing Glatopa instead of the preferred MS 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.

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**SECTION VIII – AUTHORIZED SIGNATURE**

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20. **SIGNATURE** – Prescriber

21. Date Signed

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**SECTION IX – ADDITIONAL INFORMATION**

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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.