HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Multiple Sclerosis Agents

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. The request is for renewal of a prior authorization for the Multiple Sclerosis Agent that was previously approved. If YES, go to 9.

☐ Yes ☐ No

Q2. For Zeposia (ozanimod) for the treatment of ulcerative colitis, see the prior authorization guideline related to Ulcerative Colitis Agents.

☐ Yes ☐ No

Q3. The member meets ALL of the following:

☐ Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration(FDA)-approved package labeling or a medically accepted indication

☐ Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Is prescribed a dose that is consistent with the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Does not have a contraindication to the prescribed Multiple Sclerosis Agent

Q4. The MS Agent is prescribed by one of the following:

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Multiple Sclerosis Agents

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:

☐ For Ampyra (dalfampridine ER), a neurologist or physical medicine and rehabilitation (PM&R) specialist

☐ For all other Multiple Sclerosis Agents, a neurologist

Q5. For a non-preferred Multiple Sclerosis Agent, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Multiple Sclerosis Agents approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q6. The member meets ONE of the following:

☐ Has a current prescription (within the past 90 days) for the same non-preferred Multiple Sclerosis Agent (does not apply to non-preferred Multiple Sclerosis Agents when a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic is preferred)

☐ For a non-preferred Multiple Sclerosis Agent with a dosing interval exceeding 90 days (e.g., Lemtrada, Mavenclad), is receiving treatment with the same non-preferred Multiple Sclerosis Agent and will continue therapy at a dosing interval supported by FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Q7. For Ampyra (dalfampridine ER), has motor dysfunction on a continuous basis that impairs the ability to complete instrumental activities of daily living or activities of daily living.

☐ Yes ☐ No

Q8. For Mavenclad (cladribine), has documentation of a recent lymphocyte count within recommended limits according to FDA-approved package labeling before initiating the first treatment course.

☐ Yes ☐ No

Q9. The member meets BOTH of the following:

☐ Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Does not have a contraindication to the prescribed Multiple Sclerosis Agent

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Multiple Sclerosis Agents

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:

Q10. Is prescribed the Multiple Sclerosis Agent by one of the following:

☐ For Ampyra (dalfampridine ER), a neurologist or PM&R specialist

☐ For all other Multiple Sclerosis Agents, a neurologist

Q11. For Ampyra (dalfampridine ER), has a documented improvement in motor function.

☐ Yes ☐ No

Q12. For all other Multiple Sclerosis Agents, ONE of the following:

☐ For a Multiple Sclerosis Agent prescribed for a diagnosis of a relapsing form of multiple sclerosis, has documented improvement or stabilization of the multiple sclerosis disease course

☐ For a Multiple Sclerosis Agent prescribed for a diagnosis of primary progressive multiple sclerosis or a non-relapsing form of secondary progressive multiple sclerosis, continues to benefit from the prescribed Multiple Sclerosis Agent based on the prescriber's assessment

Q13. For Lemtrada (alemtuzumab), received the previous treatment course at least 12 months prior to the requested treatment course with Lemtrada (alemtuzumab).

☐ Yes ☐ No

Q14. For Mavenclad (cladribine), both of the following:

☐ Has documentation of a recent lymphocyte count within recommended limits according to FDA-approved package labeling before initiating the second treatment course

☐ Has not exceeded the recommended total number of treatment courses according to FDA-approved package labeling

Q15. For a non-preferred Multiple Sclerosis Agent with a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug.

☐ Yes ☐ No

Q16. Additional Information:

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Multiple Sclerosis Agents

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:

Prescriber Signature _____ Date _____

v2026