HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Gilenya

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.

Patient Name:	**Prescriber Name:**
HPP Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Address:	NPI: Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*
Patient Primary Phone:	Address:
Line of Business: ☐ Medicaid ☐ CHIP	City, State ZIP:
	Specialty/facility name (if applicable):

☐ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

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. Is the patient greater than or equal to 10 years of age with a diagnosis of relapsing forms of multiple sclerosis (members with multiple sclerosis (MS) or with clinically isolated syndromes suggestive of MS who are at high risk for developing clinically definite MS)?

☐ Yes ☐ No

Q2. Is the prescribing physician a Neurologist or in consultation with a Neurologist?

☐ Yes ☐ No

Q3. Does the patient have an acute or chronic infection?

☐ Yes ☐ No

Q4. Has the patient experienced myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure requiring hospitalization or Class III/IV heart failure in the last 6 months?

☐ Yes ☐ No

Q5. Does the patient have a history or presence of Mobitz Type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless patient has a functioning pacemaker?

☐ Yes ☐ No

Q6. Does the patient have a baseline QTc interval greater than or equal to 500 msec?

☐ Yes ☐ No

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Q7. Are the results from a recent electrocardiogram (i.e. within 6 months) attached?

☐ Yes ☐ No

Q8. Are the results (i.e. within 6 months) from the following lab tests (Varicella Zoster Vaccine antibody serology, CBC, FEV1, DLCO, bilirubin and liver transaminases) attached with results within the normal range?

☐ Yes ☐ No

Q9. Has the patient received a baseline ophthalmic evaluation? Documentation must be attached.

☐ Yes ☐ No

Q10. Will GILENYA be concomitantly administered with any of the agents below? A.) Class Ia anti-arrhythmics (e.g. quinidine, procainamide, disopyramide); B.) Class III anti arryhthmics (e.g. amiodarone, sotalol, ibutilide, dofetilide, dronedarone); C.) Antineoplastics; D.) High risk QTc-prolonging agents; E.) Vaccines (live), BCG; F.) Immunosuppressives (e.g. pimecrolimus, topical tacrolimus); G.) Immune modulating therapies used for treatment of multiple sclerosis (e.g. natalizumab); H.) Ketoconazole

☐ Yes ☐ No

Q11. Will the first dose of GILENYA be administered in a setting in which resources to appropriately manage symptomatic bradycardia are available?

☐ Yes ☐ No

Q12. Will the member be observed for 6 hours for signs and symptoms of bradycardia with hourly pulse and blood pressure measurement?

☐ Yes ☐ No

Q13. Will an electrocardiogram be obtained prior to dosing, and at the end of the observation period?

☐ Yes ☐ No

Q14. Is the dose and frequency of treatment prescribed within medically accepted guidelines for use and does not exceed 0.5 mg once daily for patients 10 years and older weighing greater than 40 kg OR 0.25 mg once daily for patients 10 years and older weighing less than or equal to 40 kg?

☐ Yes ☐ No

Q15. Requested Duration:

☐ 3 Months

Q16. Additional Information:

Prescriber Signature   Date

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