HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Aubagio (teriflunomide)

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 medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. If female, is she pregnant or planning to become pregnant?

☐ Yes ☐ No

Q4. If male, is he with a female partner who is pregnant or planning to become pregnant?

☐ Yes ☐ No

Q5. Will the patient or the female partner of the patient use reliable forms of contraception?

☐ Yes ☐ No

Q6. Will the patient (if female) or patient's partner (if female) have monthly pregnancy tests during therapy?

☐ Yes ☐ No

Q7. Does the patient have a diagnosis of relapsing forms of multiple sclerosis?

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☐ Yes ☐ No

Q8. Does the patient have one of the following conditions?
a. Severe immunodeficiency
b. Bone marrow dysplasia
c. Severe and/or uncontrolled infections

☐ Yes ☐ No

Q9. Is the patient currently taking leflunomide or Arava®?

☐ Yes ☐ No

Q10. Were the following baseline labs drawn? (Please attach documentation.)
Alanine aminotransferase, bilirubin levels, serum potassium, serum creatinine
CBC?

☐ Yes ☐ No

Q11. Are the above labs within normal limits?

☐ Yes ☐ No

Q12. Has patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q13. Is the tuberculin skin test negative?

☐ Yes ☐ No

Q14. If latent infection is diagnosed, has the patient received appropriate treatment in accordance with the CDC and prevention guidelines?

☐ Yes ☐ No

Q15. Is the patient being treated for any other active infection?

☐ Yes ☐ No

Q16. Has patient's immunizations been brought up to date?

☐ Yes ☐ No

Q17. Will the following parameters be monitored periodically?
Alanine aminotransferase, bilirubin levels, serum potassium, serum creatinine (baseline, monthly for at least 6 months once treatment is started)CBC (within 6 months of initiation and periodically thereafter based on signs/symptoms of infection)

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q18. Requested Duration:

☐ 12 months

Q19. Additional information: _____

_______________________________ Prescriber Signature

_______________________________ Date

Updated 2018

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