Health Partners Plans

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.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient 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. Is the request for a renewal of prior authorization for the drug previously approved?

☐ Yes ☐ No

Q2. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q3. Is the patient prescribed a dose that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the patient age-appropriate for the requested drug according to the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed literature?

☐ Yes ☐ No

Q5. Does the patient have a history of a contraindication to the requested drug?

☐ Yes ☐ No

Q6. Have all potential drug interactions been addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact)?

☐ Yes ☐ No

Q7. Is the requested drug being prescribed by one of the following: A) neurologist, or B) physical medicine and

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Patient Name:	Prescriber Name:

rehabilitation (PM&R) specialist (for Ampyra/dalfampridine only)?

☐ Yes ☐ No

Q8. Is the requested drug Lemtrada (alemtuzumab)?

☐ Yes ☐ No

Q9. Does the patient have one of the following: A) Documentation of positive antibodies for varicella zoster virus (VZV), B) Documentation of vaccination for VZV, OR C) A healthcare professional confirmed history of chickenpox?

☐ Yes ☐ No

Q10. Has the patient received a varicella zoster virus (VZV) vaccine within the previous six weeks?

☐ Yes ☐ No

Q11. Does the patient have documentation of a recent negative purified protein derivative (PPD) test or blood test for tuberculosis?

☐ Yes ☐ No

Q12. Is the requested drug Mavenclad (cladribine)?

☐ Yes ☐ No

Q13. Does the patient have documentation of recent lymphocyte count within recommended limits according to the Food and Drug Administration (FDA)-approved package labeling before initiating the first treatment course?

☐ Yes ☐ No

Q14. Does the patient have one of the following: A) Documentation of positive antibodies to varicella zoster virus (VZV), B) Documentation of vaccination for VZV, OR C) A healthcare professional confirmed history of chickenpox?

☐ Yes ☐ No

Q15. Is the requested drug Ampyra or dalfampridine?

☐ Yes ☐ No

Q16. Does the patient have motor dysfunction on a continuous basis that impairs the ability to complete instrumental activities of daily living (IADL's) or activities of daily living (ADL's)?

☐ Yes ☐ No

Q17. Is the requested drug generic dalfampridine?

☐ Yes ☐ No

Q18. Is the requested drug Aubagio (teriflunomide)?

☐ Yes ☐ No

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Q19. Does the patient have a diagnosis of severe immunodeficiency, bone marrow disease, or severe, uncontrolled infection?

☐ Yes ☐ No

Q20. Does the patient have documentation of a recent negative purified protein derivative (PPD) test or blood test for tuberculosis?

☐ Yes ☐ No

Q21. Is the requested drug Gilenya (fingolimod)?

☐ Yes ☐ No

Q22. Does the patient have one of the following: A) Documentation of positive antibodies to varicella zoster virus (VZV), B) Documentation of vaccination for VZV, OR C) A healthcare professional confirmed history of chickenpox?

☐ Yes ☐ No

Q23. Has the patient received a varicella zoster virus (VZV) vaccination in the previous one month?

☐ Yes ☐ No

Q24. Is the requested drug Ocrevus (ocrelizumab)?

☐ Yes ☐ No

Q25. Does the patient have evidence of significant active infection?

☐ Yes ☐ No

Q26. Is the requested drug Mayzent (siponimod)?

☐ Yes ☐ No

Q27. Does the patient have one of the following: A) Documentation of positive antibodies to varicella zoster virus (VZV), B) Documentation of vaccination for VZV, OR C) A healthcare professional confirmed history of chickenpox?

☐ Yes ☐ No

Q28. Does the patient have documentation of prescriber consultation with a cardiologist if recommended in the Food and Drug Administration (FDA)-approved package labeling? If not recommended in the FDA-approved package labeling, select Yes.

☐ Yes ☐ No

Q29. Is the requested drug Zeposia (ozanimod)?

☐ Yes ☐ No

Q30. Does the patient have one of the following: A) Documentation of positive antibodies to varicella zoster virus

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(VZV), B) Documentation of vaccination for VZV, OR C) A healthcare professional confirmed history of chickenpox?

☐ Yes ☐ No

Q31. Is the requested drug a non-preferred agent?

☐ Yes ☐ No

Q32. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred multiple sclerosis agents approved for the patient's diagnosis?

☐ Yes ☐ No

Q33. Does the patient have a current prescription (within the past 90 days) for the same non-preferred multiple sclerosis agent OR if the dosing interval exceeds 90 days, is the patient 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 literature?

☐ Yes ☐ No

Q34. Is the requested drug being prescribed by one of the following: A) neurologist, or B) physical medicine and rehabilitation (PM&R) specialist (for Ampyra/dalfampridine only)?

☐ Yes ☐ No

Q35. Is the patient prescribed a dose that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q36. Does the patient have a history of a contraindication to the requested drug?

☐ Yes ☐ No

Q37. Have all potential drug interactions been addressed by the prescriber by one of the following: A) Discontinuation of the interacting drug, B) Dose reduction of the interacting drug, OR C) Counseling the beneficiary of the risks associated with the use of both medications when they interact?

☐ Yes ☐ No

Q38. Is the requested drug brand Ampyra (dalfampridine)?

☐ Yes ☐ No

Q39. Does the patient have documentation of improvement in motor function?

☐ Yes ☐ No

Q40. Is the requested drug being used for a diagnosis of a relapsing form of multiple sclerosis?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q41. Does the patient have documentation of improvement or stabilization of the multiple sclerosis disease course?

☐ Yes ☐ No

Q42. Is the requested drug being used for a diagnosis of primary progressive multiple sclerosis?

☐ Yes ☐ No

Q43. Does the patient continue to benefit from the prescribed multiple sclerosis agent based on the prescriber's professional judgement?

☐ Yes ☐ No

Q44. Is the requested drug Lemtrada (alemtuzumab)?

☐ Yes ☐ No

Q45. Did the patient receive the previous treatment course at least 12 months prior to the requested treatment course with Lemtrada (alemtuzumab)?

☐ Yes ☐ No

Q46. Does the patient have signs of malignancy or autoimmune disorder?

☐ Yes ☐ No

Q47. Is the requested drug Aubagio (teriflunomide)?

☐ Yes ☐ No

Q48. Does the patient have a diagnosis of severe immunodeficiency, bone marrow disease, or severe, uncontrolled infection?

☐ Yes ☐ No

Q49. Is the requested drug Ocrevus (ocrelizumab)?

☐ Yes ☐ No

Q50. Does the patient have evidence of significant active infection?

☐ Yes ☐ No

Q51. Is the requested drug Mavenclad (cladribine)?

☐ Yes ☐ No

Q52. Does the patient have documentation of recent lymphocyte count within recommended limits according to the Food and Drug Administration (FDA)-approved package labeling before initiating the second treatment course?

☐ Yes ☐ No

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Q53. Has the patient exceeded the recommended total number of treatment courses according to the Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q54. Is the requested drug Mayzent (siponimod)?

☐ Yes ☐ No

Q55. Does the patient have documentation of prescriber consultation with a cardiologist if recommended in the Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q56. Additional Information:

Prescriber Signature

Date

Updated for 2021