SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Multiple Sclerosis Drugs

Drug Requested: (Check below the drug that applies)

PREFERRED DRUGS		
❑ **Aubagio®**	❑ **Avonex®**	❑ **Avonex® Adm Pack**
❑ **Betaseron®**	❑ **Copaxone® 20 mg syringe**	❑ **dalfampridine ER** (generic for Ampyra®)** **(PA required)**
❑ **dimethyl fumarate and starter pack** (generic Tecfidera™)	❑ **fingolimod** (generic Gilenya®)	❑ **Kesimpta® (Step Edit)**
Non-Preferred Drugs **All Non-Preferred Medications Require Prior Authorization (member must have tried and failed at least two (2) of the preferred MS drugs)**		
❑ **Ampyra®** (PA required)**	❑ **Bafiertam®**	❑ **Copaxone® 40 mg syringe**
❑ **Extavia® Kit**	❑ **Gilenya®**	❑ **glatiramer 20mg syringe**
❑ **Glatopa™**	❑ **Mavenclad®** (PA required)**	❑ **Mayzent®** (PA required)**
❑ **Plegridy®**	❑ **Ponvory™**	❑ **Rebif® SQ**
❑ **Rebif® Rebidose Pen®**	❑ **Tascenso (fingolimod) ODT®**	❑ **Tecfidera®** ❑ **Tecfidera® Starter Pack**
❑ **teriflunomide** (generic Aubagio®)	❑ **Vumerity®**	❑ **Zeposia® (PA required)**
❑ **Zinbryta®**		

(Please note: Ampyra®, Mavenclad®, Ponvory™, Zeposia®, and Mayzent® require a separate PA form)

**** All agents require adherence to the documented package insert age and diagnosis.**

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MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Patient has tried and failed at least **two (2)** of the following **PREFERRED** drugs:

❑ **Aubagio®**	❑ **Avonex®**	❑ **Betaseron®**
❑ **Copaxone® 20 mg syringe®**	❑ **Dimethyl fumarate** (generic Tecfidera™)	❑ **fingolimod** (generic Gilenya®)
❑ **Kesimpta® (step edit)**		

- ❑ Provide clinical evidence that the **Preferred** drug(s) will not provide adequate benefit and list pharmaceutical drugs attempted and outcome.

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_____

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Step-Edit for Kesimpta®:

- ❑ Trial and failure of dimethyl fumarate (generic Tecfidera®) or a **preferred injectable** is required for approval ❑ Yes ❑ No

  If **YES,** provide drug name/form/strength: _____

MEDICAL NECESSITY: Provide clinical evidence that the **Preferred injectable drug** will not provide adequate benefit.

_____

_____

_____

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_____

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.