



Please Note: Medical Necessity Prior Authorization may be overridden for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION **BYPASS**

Gilenya® (fingolimod)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Name _____
 Address _____

Rx

Refer for
 Multiple
 Sclerosis
 Protocol

as directed by physician

MD _____
 Signature _____

Name _____
 Address _____

Rx Compounded, low dose
 naltrexone 0.5mg
 quantity # sig: 1.5 to
 4.5mg daily; limit
 dosage to 3mg if
 evidence of spasticity

Dx: MULTIPLE SCLEROSIS

ICD 10: G 353.

MD _____
 Signature _____

SAMPLE



Prescriber Information

Last Name: <input type="text"/> DEA/NPI: <input type="text"/> Phone <input type="text"/>	First Name <input type="text"/> Specialty: <input type="text"/> Fax <input type="text"/>
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Member Information

Last Name: <input type="text"/> Member ID Number <input type="text"/>	First Name <input type="text"/> DOB: <input type="text"/>
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Medication Information:

Drug Name and Strength: <hr/> Diagnosis: <hr/>	Quantity and Dosing: <hr/> Duration: <hr/>
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When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Gilenya Prior Authorization Form

Initial Therapy		
You must answer ALL of the following questions		
1. Is the medication being prescribed by a neurologist?	Y	N
2. Is the patient between 18 and 65 years of age?	Y	N
3. Is the patient diagnosed with a relapsing form of multiple sclerosis (relapsing-remitting multiple sclerosis, progressive-relapsing multiple sclerosis and secondary progressive multiple sclerosis)?	Y	N
4. Has the patient tried and had an inadequate response to a three month trial of Avonex?	Y	N
5. Has the patient had prior treatment with Rebif, Betaseron or Extavia?	Y	N
6. Has the patient tried and had an inadequate response to a three month trial of Copaxone?	Y	N
7. Has the patient had prior treatment with Tysabri?	Y	N
8. Has the patient had a positive anti-JC antibody test?	Y	N
9. Has the patient tried and had an inadequate response to a three month trial of one of the following therapies? (Please Circle)	Y	N
<ul style="list-style-type: none"> • Copaxone • Beta interferon (e.g., Rebif, Avonex, Betaseron, Extavia) • Tysabri 		

Renewal Therapy		
You must answer ALL of the following questions		
1. Is the medication being prescribed by a neurologist?	Y	N



2. Is the patient continuing to have a positive clinical response, and is remission of disease maintained with continued use?

Y

N

Please provide supporting chart notes.

Please note, not all drugs/diagnoses are covered on all plans.

Comments: _____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the "For Providers" tab.Cover Page. Print a new form for each request as forms are updated periodically.

Prescriber or Authorized Signature

Date

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear on the Cover Page

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).



Contact Information:

Telephone: (855)251.9116

Fax: (248)593.9575

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**PRIOR AUTHORIZATION FORM:
COVER PAGE**

MEMBER INFORMATION			
First Name		Last Name	
Plan			
Member ID		Date of Birth	
DRUG INFORMATION			
Drug Name			
Quantity		ICD-10	
Directions		Duration of Therapy	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
Medication/Failure Reason:			
IgE: _____			
ESR: _____ CRP: _____ # Joints: _____ %BSA: _____			
Height: _____ Weight: _____ BMI: _____			
HA1C: _____ Hemoglobin: _____ Hematocrit: _____ T-Score: _____			
Dialysis: _____ Long Term Care Facility: _____ Self Injecting: _____			
Stimulation test: _____ / _____ Growth velocity: _____ #Chemotherapy cycles/month: _____			
Mini-Mental Status Test: _____ Baseline Free testosterone/Total testosterone: _____ / _____			
HCV RNA viral load: _____ Viral Genotype: _____ ALT: _____			
PHYSICIAN INFORMATION			
Physician Signature		Date	
Physician Name		NPI #	
Phone Number		Fax Number	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function		Pharmacy Fax
	<input type="checkbox"/> Urgent <input type="checkbox"/> For Review		
The information contained in this facsimile message, including the attachments, may be privileged, may constitute inside information and is intended only for use of the addressee. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited and may be unlawful. If you have received this communication in error, please immediately notify me by replying to this message and destroy the original message.			