aetna™

Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Multiple Sclerosis Agents
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information						
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female				Height:
Member ID:	City:	State:				Weight:
Prescribing Provider Information						
Provider Name (first & last):	Specialty:	NPI#				DEA#
Office Address:	City:	State:				Zip Code:
Office Contact:	Office Phone	Office Fax:				
Dispensing Pharmacy Information						
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:				
Requested Medication Information						
Preferred Agents:	☐ Copaxone	☐ Tecfidera				
Non-Preferred Agents:	☐ Glatiramer Acetate	☐ Aubagio	☐ Avonex	☐ Extavia	☐ Ocrevus	☐ Vumerity
	☐ Gilenya	☐ Glatopa	☐ Rebif / Rebidose	☐ Betaseron	☐ Plegridy	☐ Mavenclad
	☐ Lemtrada	☐ Mayzent	☐ Mitoxantrone	☐ Tysabri		
Other, please specify:						
Medication request is NOT for an FDA approved OR compendia supported diagnosis (circle one): ☐Yes ☐No	ICD-10 Code:	Diagnosis:				
What medication(s) have been tried and failed for diagnosis?						
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ Initial request			
☐ Continuation of therapy ONLY:	Was there response to treatment AND no serious toxicity AS result of treatment? (LVEF, CBC, ANC, ECG)?	☐ Yes	☐ No			
Directions for Use:	Strength:	Dosage Form:				
	Quantity:	Day Supply:	Duration of Therapy/Use:			
Turn-Around Time for Review						
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____					
Clinical Information						
Will other disease modifying MS therapies (not including Ampyra) be discontinued OR have been discontinued?	☐ Yes	☐ No				
INJECTABLE AGENTS						
☐ Copaxone (40mg)	☐ Glatopa (20mg glatiramer acetate)	☐ Extavia (interferon beta-1b)	☐ Avonex (interferon beta-1a)	☐ Rebif/Rebidose (interferon beta-1a)		
Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active	☐ Yes	☐ No	

AND have MRI features consistent with MS)?			secondary progressive MS)?		
☐ Betaseron (Interferon beta-1b)			☐ Plegridy (peg-interferon beta-1a)		
Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
Was there inadequate response, intolerable side effect OR contraindication with TWO formulary agents, ONE of which was an interferon OR glatiramer acetate?				☐ Yes	☐ No
ORAL AGENTS					
☐ Aubagio					
Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
Is member FEMALE of reproductive potential?	☐ Yes	☐ No	Is member pregnant?	☐ Yes ☐ No	☐ N/A
Will member be using effective contraception during treatment?				☐ Yes ☐ No	☐ N/A
The following LABS have been completed within last SIX months:	☐ CBC	☐ LFTs and bilirubin	☐ Tuberculin skin test		
☐ Gilenya					
Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
The following LABS have been completed within the last SIX months:	☐ CBC	☐ LFTs and bilirubin	☐ Electrocardiogram	☐ Ophthalmic examination	
Documented history of ONE of the following:	☐ Chicken pox		☐ Varicella zoster vaccination	☐ Evidence of immunity (positive antibodies)	
Documented history of ANY of the following:	☐ MI, unstable angina, stroke, TIA, decompensated HF requiring hospitalization OR class III/IV HF within past SIX months		☐ History of Mobitz type II (2nd OR 3rd degree AV block) OR sick sinus syndrome, unless member has pacemaker		
	☐ Corrected QTc ≥500 msec		☐ Treatment with Class Ia OR Class III anti-arrhythmic drugs		
☐ Mayzent					
Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
Was member tested for CYP2C9 variants to determine CYP2C9 genotype?	☐ Yes	☐ No	Is member positive for CYP2C9*3/*3?	☐ Yes	☐ No
The following LABS have been completed within last SIX months:	☐ CBC	☐ LFTs and bilirubin	☐ Electrocardiogram	☐ Ophthalmic examination	
Documented history of ONE of the following:	☐ chicken pox		☐ varicella zoster vaccination	☐ evidence of immunity (positive antibodies)	
Documented history of ANY of the following:	☐ MI, unstable angina, stroke, TIA, decompensated HF requiring hospitalization OR class III/IV HF within past SIX months		☐ History of Mobitz type II (2nd OR 3rd degree AV block) OR sick sinus syndrome, unless member has pacemaker		
☐ Mavenclad					
Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
Was baseline (within 3 months) MRI scan obtained prior to starting treatment course due to risk of PML?	☐ Yes	☐ No	Is member infected with HIV AND has active chronic infections (hepatitis OR tuberculosis) OR is breastfeeding (during treatment OR for 10 days after last dose)?	☐ Yes	☐ No
Is member a FEMALE of reproductive potential?	☐ Yes	☐ No	Is member pregnant?	☐ Yes ☐ No	☐ N/A
Will member be using effective contraception during treatment?				☐ Yes ☐ No	☐ N/A
Has member received lifetime MAX of 2 courses (4 cycles) of therapy?				☐ Yes ☐ No	
☐ Tecfidera			☐ Vumerity		

Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
The following LABS have been completed within last SIX months:			☐ CBC	☐ LFTs and bilirubin	

INFUSIONS

☐ Ocrevus

Was member screened for Hepatitis B?	☐ Yes	☐ No	Does member have active Hepatitis B infection?	☐ Yes	☐ No
Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
Is diagnosis of Primary-Progressive Multiple Sclerosis?	☐ Yes	☐ No	Was there inadequate response, intolerable side effect OR contraindication to TWO formulary agents, one of which must be an interferon OR glatiramer acetate?	☐ Yes	☐ No

☐ Lemtrada

Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No	Will treatment exceed FIVE days the first year, AND THREE days the 2nd year?	☐ Yes	☐ No
Is member infected with HIV?	☐ Yes	☐ No			

The following been completed prior to starting treatment?	☐ CBC	☐ Necessary immunizations	☐ Serum creatinine levels
	☐ History of varicella OR varicella zoster vaccination OR evidence of immunity (positive antibodies)		
	☐ Screened for TB. If screening was positive, treatment was received		☐ Thyroid function test

☐ Tysabri

Does member have clinically isolated syndrome suggestive of MS (experienced 1st clinical episode AND have MRI features consistent with MS)?	☐ Yes	☐ No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	☐ Yes	☐ No
Was anti-JCV antibody test (ELISA [enzyme-linked immunosorbent assay]) completed?				☐ Yes	☐ No

☐ Mitoxantrone

Member has ANY of the following:	☐ Worsening relapsing-remitting MS to reduce neurologic disability AND/OR frequency of clinical relapse	☐ Secondary (chronic) progressive MS	☐ Progressive relapsing MS	☐ Primary progressive MS
Was cumulative lifetime dose exceeded?		☐ Yes	☐ No	
The following labs have been completed within last SIX months:		☐ LVEF >50% (not below lower limit of normal)		☐ ANC >1500 cells/mm3
		☐ CBC		☐ LFTs

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.