



Fax completed prior authorization request form to 855-799-2551 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

Aetna Better Health®

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

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/michigan/providers/medicaid/pharmacy

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: <input type="checkbox"/> Male <input type="checkbox"/> 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			
<input type="checkbox"/> Aubagio®	<input type="checkbox"/> Bafiertam™	<input type="checkbox"/> Copaxone® 40 mg	<input type="checkbox"/> Cladribine 10mg
<input type="checkbox"/> Glatiramer 20mg/ml and 40 mg/ml	<input type="checkbox"/> Gilenya®	<input type="checkbox"/> Glatopa®	<input type="checkbox"/> Mavenclad®
<input type="checkbox"/> Mayzent®	<input type="checkbox"/> Plegridy®	<input type="checkbox"/> Ponvory®	<input type="checkbox"/> Rebif® / Rebif Rebidose®
<input type="checkbox"/> Tascenso ODT®	<input type="checkbox"/> Tecfidera®	<input type="checkbox"/> Vumerity®	<input type="checkbox"/> Zeposia®
<input type="checkbox"/> 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? (please specify):			
Has the member had a therapeutic failure after one-month trial with two preferred medications?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member have any of the following to the preferred medication(s): (check all that apply)		<input type="checkbox"/> Allergy <input type="checkbox"/> Contraindication or drug interactions <input type="checkbox"/> History of unacceptable side effects	
Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:
Turn-Around Time for Review			

<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> 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: _____	
Bafiertam			
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prescriber attests that Bafiertam will be used as single agent monotherapy		<input type="checkbox"/> Yes	<input type="checkbox"/> No
RENEWAL of Bafiertam:	<input type="checkbox"/> Attestation of tolerance to maintenance dose	<input type="checkbox"/> Attestation of a CBC, including lymphocyte count, serum aminotransferase, ALP, and total bilirubin levels	
Plegridy, Mavenclad, Mayzent, Vumerity, Zeposia			
Has the member had a therapeutic failure of one-month trial of at least two preferred medications?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ponvory			
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Member has obtained a baseline electrocardiogram (ECG)	<input type="checkbox"/> Prescriber attests that first-dose monitoring, as clinically indicated, will occur	<input type="checkbox"/> Member does NOT have an active infection, including clinically important localized infections	<input type="checkbox"/> Member has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy
For members with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prescriber attests that ponosimod will NOT be used in combination with anti-neoplastic, immunosuppressive, or immune-modulating therapies, or, if therapy is unavoidable, the member will be monitored closely for adverse reactions and/or dose modifications?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the member had a therapeutic failure of one-month trial of at least two preferred medications?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mavenclad			
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include relapsing-remitting disease and active secondary progressive disease?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mayzent			
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Member CYP2C9 variant status has been tested to determine genotyping (required for dosing)	<input type="checkbox"/> Member has obtained a baseline electrocardiogram (ECG)	<input type="checkbox"/> Member has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy	<input type="checkbox"/> Members with a history of uveitis and/or diabetes ONLY; a baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment
Tascenso ODT			
Does the member have a diagnosis of a relapsing form of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) or active secondary progressive disease (SPMS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the member unable to use generic fingolimod capsules or brand Gilenya capsules due to swallowing difficulties?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vumerity			
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Zeposia			
Does the member have a diagnosis of moderately or severely active ulcerative colitis (UC) and is prescribed by or in consultation with a gastroenterologist?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the member have a diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Member has obtained a baseline	<input type="checkbox"/> Member does NOT have an active infection,	<input type="checkbox"/> Member has been tested for antibodies to the	<input type="checkbox"/> Members with a history of uveitis and/or diabetes

electrocardiogram (ECG)	including clinically important localized infections	varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy	ONLY; a baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment
Prescriber attests that a CBC with lymphocyte count, ALT, AST, and total bilirubin have been obtained for the member in the past 6 months?			<input type="checkbox"/> Yes <input type="checkbox"/> No
For MS, has the member had a therapeutic failure of one-month trial of at least two preferred medications?			<input type="checkbox"/> Yes <input type="checkbox"/> No

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 855-300-5528 to check the status of a request.