

**Multiple Sclerosis Agents
 Clinical Prior Authorization (PA) Request Form
 CT Medical Assistance Program
To Be Completed By Prescriber**

<u>Prescriber Information</u>	<u>Patient Information</u>
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient DOB:
Phone ()	Patient Current Weight:
Fax ()	Patient Primary ICD Diagnosis Code:
<u>Prescription Information</u>	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation	Quantity Requested:

<u>Preferred Agents:</u>	<u>Non-Preferred Agents:</u>	
AVONEX PEN, PREFILLED SYRINGE	AMPYRA ER TABLET	PLEGRIDY PEN
BETASERON 0.3 MG KIT	AUBAGIO TABLET	PONVORY STARTER PACK
COPAXONE 20 MG/ML SYR (not 40 MG/ML)	BAFIERTAM DR CAPSULE	PONVORY TABLET
(BRAND PREFERRED)	BETASERON VIAL	REBIF SYRINGE
DALFAMPRIDINE ER TABLET	BRIUMVI VIAL	REBIF REBIDOSE
DIMETHYL FUMARATE DR CAPSULE	COPAXONE 40 MG/ML SYR	REBIF TITRATION PACK
DIMETHYL FUMARATE DR STARTER PACK	GILENYA CAPSULE	TASCENSO ODT TABLET
FINGOLIMOD CAPSULE	GLATIRAMER SYRINGE	TECFIDERA DR CAPSULE
KESIMPTA PEN	GLATOPA SYRINGE	TECFIDERA STARTER PK
TERIFLUNOMIDE TABLET	LEMTRADA VIAL	TYRUKO VIAL
	MAVENCLAD TABLET PK	TYSABRI VIAL
	MAYZENT TABLET	VUMERITY DR CAPSULE
	OCREVUS VIAL	ZEPOSIA CAPSULE
	OCREVUS ZUNOVO VIAL	ZEPOSIA STARTER PACK

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

<p>1. Prescribed by or in consultation with neurologist, gastroenterologist or other specialist in the treated disease state (as appropriate for diagnosis)</p> <p>Please specify subspecialty: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Will requested medication be used as adjunctive therapy with another immunosuppressant (e.g., 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate) or TNFi agent?</p> <p>If so, please specify other agent: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. For diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS): Patient failed to achieve desired therapeutic outcome with a trial of ONE preferred oral (excluding dalfampridine) or injectable multiple sclerosis (MS) agent for a minimum of 30 days OR documented adverse drug event/adverse drug reaction (ADE/ADR) or contraindication to preferred products?</p> <p>○ Preferred agent trialed: _____</p> <p>○ Trial Dates: _____</p> <p>○ Reason for Failure: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>4. For diagnosis of Moderate-to-Severe Crohn's Disease (CD): Patient failed to achieve desired therapeutic outcome with a trial of ONE preferred tumor necrosis factor inhibitor (TNFi) AND conventional Crohn's disease therapies OR documented adverse event/adverse drug reaction or contraindication to both classes of drug</p> <p>○ Preferred TNFi agent trialed: _____</p> <p>○ Trial Dates: _____</p> <p>○ Reason for Contraindication or Failure: _____</p> <p>○ Conventional Crohn's disease therapy trialed: _____</p> <p>_____</p> <p>○ Trial Dates: _____</p> <p>○ Reason for Contraindication or Failure: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>5. For diagnosis of Moderate-to-Severe Ulcerative Colitis (UC): Patient failed to achieve desired therapeutic outcome with a trial of ONE preferred tumor necrosis factor inhibitor (TNFi) OR</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

<p>preferred ustekinumab biosimilar OR documented adverse event/adverse reaction or contraindication to TNFi and Ustekinumab biosimilars</p> <ul style="list-style-type: none"> ○ Preferred agent trialed: _____ ○ Trial Dates: _____ ○ Reason for Contraindication or Failure: _____ 	
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For Initial Approval:
Medication Requested and diagnosis of ONE of the following:
 (attach supporting documentation, required)

<p><u>Ampyra (dalfampridine) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) AND • Documented medical reason why the preferred GENERIC formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Aubagio (teriflunomide) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) AND • Documented medical reason why the preferred GENERIC formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Bafiertam DR (monomethyl fumarate) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Betaseron Vial (interferon beta-1b) (18+ years of age):</u></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) AND • Documented medical reason why the preferred BETASERON KIT formulation cannot be used: _____ 	
<p><u>Briumvi Vial (ublituximab) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) AND • Supporting documentation of ALL the following prior to starting therapy: <ul style="list-style-type: none"> ○ Hepatitis B screening <u>negative</u> ○ Quantitative serum immunoglobulins ○ Liver function tests 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Copaxone 40 mg/ml Syringe (glatiramer) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) AND • Documented medical reason why the preferred COPAXONE 20MG/ML formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Gilenya (fingolimod) (10+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • For Gilenya 0.5 mg: Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) AND • Documented medical reason why the generic FINGOLIMOD 0.5 MG CAPSULE cannot be used: _____ <p>OR</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> • For Gilenya 0.25 mg: Patient is 10 years and older and weighs less than or equal to 40 kg. (Trial and failure of a preferred agent not required) 	
<p><u>Glatiramer Syringe (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) AND • Documented medical reason why the preferred COPAXONE 20MG/ML formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Glatopa Syringe (glatiramer) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) AND • Documented medical reason why the preferred COPAXONE 20MG/ML formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Lemtrada (alemtuzumab) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Multiple Sclerosis (MS) AND • Provider attests to having met the REMS requirements for counseling and monitoring and patient is NOT pregnant AND • Prescriber attests to ALL of the following: <ul style="list-style-type: none"> ○ Lemtrada is NOT being used for Clinically Isolated Syndrome CIS ○ Patient has documented <u>negative</u> HIV test ○ Lemtrada will not be administered during active infections • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) AND • Trial and failure of ONE <u>additional medication</u> approved for the treatment of MS OR Documented 	<input type="checkbox"/> Yes <input type="checkbox"/> No

medical reason for why a trial of only one agent is appropriate:

Mavenclad (cladribine) (18+ years of age):

Yes No

- Patient has a documented diagnosis of Multiple Sclerosis (MS) **AND**
- Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section)
AND
- Supporting documentation/attestation of **ALL** the following prior to each Mavenclad course:
 - Standard guideline directed cancer screenings have been completed, and patient does **NOT** have a current malignancy
 - Pregnancy testing in females of reproductive potential and patient is **NOT** pregnant
 - Baseline MRI because of the risk of progressive multifocal leukoencephalopathy (PML)
 - Complete blood count with lymphocytes **AND** lymphocytes are within normal limit prior to first treatment course **OR** are at least 800 cells per microliter before initiating the second treatment course
 - Liver function tests
 - Lack of acute or active, chronic infections, including (provide documentation):
 - Tuberculosis screening negative
 - Hepatitis B and C screening negative
 - Human immunodeficiency virus (HIV) screening negative
 - Varicella zoster antibody or vaccination status

NOTE: Initial and Continuation Prior Authorization lengths will be limited to a 4 months duration and therapy will deny if patient has already received 2 treatment courses and an additional course is requested within 2 years

Mayzent (siponimod) (18+ years of age):

Yes No

- Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) **AND**
- Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section)
AND
- Prescriber attests to **ALL** of the following prior to starting therapy (provide documentation):
 - Patient is CYP2C9*3/*3 genotype negative

<ul style="list-style-type: none"> ○ Complete blood count with lymphocytes ○ Ophthalmic evaluation ○ Liver function tests ○ Varicella zoster antibody or vaccination status ○ Cardiac evaluation (electrocardiogram) AND <ul style="list-style-type: none"> ▪ Patient does NOT have presence of Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless patient has a functioning pacemaker ▪ Patient has NOT experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III or IV heart failure in the last 6 months 	
<p><u>Ocrevus and Ocrevus Zunovo (ocrelizumab and ocrelizumab and hyaluronidase-ocsg) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS), Multiple Sclerosis (MS) including Primary Progressive Multiple Sclerosis (PPMS) AND • Prescriber attests to ALL the following prior to starting therapy (provide documentation): <ul style="list-style-type: none"> ○ Hepatitis B screening <u>negative</u> ○ Quantitative serum immunoglobulins ○ Liver function tests AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) <u>unless</u> diagnosis is for primary progressive multiple sclerosis (documentation required of PPMS diagnosis) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Plegridy (peginterferon beta-1a) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Ponvory (ponesimod) (18+ years of age)</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>AND</p> <ul style="list-style-type: none"> • Prescriber attests to ALL the following prior to starting therapy (provide documentation): <ul style="list-style-type: none"> ○ Complete blood count with lymphocytes ○ Ophthalmic evaluation ○ Liver function tests ○ Varicella zoster antibody or vaccination status ○ Cardiac evaluation (electrocardiogram) AND <ul style="list-style-type: none"> ▪ Patient does NOT have presence of Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless patient has a functioning pacemaker ▪ Patient has NOT experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III or IV heart failure in the last 6 months 	
<p><u>Rebif Formulations (interferon beta-1a) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Tascenso ODT (fingolimod) (10+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • For Tascenso ODT 0.25 mg dosing: Patient weighs less than or equal to 40 kg (Trial and failure of a preferred agent not required) • For Tascenso ODT 0.5 mg: Documented medical reason why GENERIC preferred fingolimod formulation cannot be used: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Tecfidera DR (dimethyl fumarate) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) AND • Documented medical reason why GENERIC preferred formulation cannot be used: 	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p><u>Tyruko (natalizumab-sztn) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS), Multiple Sclerosis (MS) or Moderate to Severe Crohn’s Disease (CD) AND • Prescriber attests to ALL the following prior to starting therapy: <ul style="list-style-type: none"> ○ Patient met the REMS requirements for counseling and monitoring ○ Patient does NOT have and has NO history of progressive multifocal leukoencephalopathy (PML) ○ <u>For treatment of MS:</u> Tyruko will not be combined with immunosuppressants and will be used as monotherapy ○ <u>For treatment of CD:</u> Tyruko will not be combined with immunosuppressants (e.g., 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate) or TNFi AND • Failure of a preferred agent(s) (as outlined above in Question 3 OR 4 of the Clinical Information section) <p><i>NOTE: Initial Prior Authorization length will be limited to a 6 months duration for Crohn’s disease indication</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>Tysabri (natalizumab) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS), Multiple Sclerosis (MS) or Moderate to Severe Crohn’s Disease (CD) AND • Prescriber attests to ALL the following prior to starting therapy: <ul style="list-style-type: none"> ○ Patient met the REMS requirements for counseling and monitoring ○ Patient does NOT have and has NO history of progressive multifocal leukoencephalopathy (PML) ○ <u>For treatment of MS:</u> Tysabri will not be combined with immunosuppressants and will be used as monotherapy ○ <u>For treatment of CD:</u> Tysabri will not be combined with immunosuppressants (e.g., 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate) or TNFi AND • Failure of a preferred agent(s) (as outlined above in Question 3 OR 4 of the Clinical Information section) <p><i>NOTE: Initial Prior Authorization length will be limited to a 6 months duration for Crohn’s disease</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<i>indication</i>	
<p><u>Vumerity (diroximel fumarate) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS) or Multiple Sclerosis (MS) AND • Failure of a preferred agent (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Zeposia (ozanimod) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Clinically Isolated Syndrome (CIS), Multiple Sclerosis (MS) or Ulcerative Colitis (UC) AND • Failure of a preferred agent (as outlined above in Question 3 OR 5 of the Clinical Information section) AND • Prescriber attests to ALL the following prior to starting therapy (provide documentation): <ul style="list-style-type: none"> ○ Complete blood count with lymphocytes ○ Ophthalmic evaluation ○ Liver function tests ○ Varicella zoster antibody or vaccination status ○ Cardiac evaluation (electrocardiogram) AND <ul style="list-style-type: none"> ▪ Patient does NOT have presence of Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless patient has a functioning pacemaker ▪ Patient has NOT experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III or IV heart failure in the last 6 months ○ Patient does NOT have severe untreated sleep apnea ○ Patient is NOT taking a monoamine oxidase inhibitor (ex. Isocarboxazid (Marplan), Phenelzine (Nardil), Tranylcypromine (Parnate), and Selegiline (Emsam)) 	<input type="checkbox"/> Yes <input type="checkbox"/> No

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

<ul style="list-style-type: none"> • Has the patient previously met the required criteria set forth in Initial Approval Section above? <ul style="list-style-type: none"> ○ Previous Approved Prior Authorization Number: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
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○ Approval Dates: _____	
● Patients' clinical response to treatment and ongoing safety has been documented and monitored	<input type="checkbox"/> Yes <input type="checkbox"/> No
● Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen	<input type="checkbox"/> Yes <input type="checkbox"/> No
● For specific formulation requests: <ul style="list-style-type: none"> ○ For brand requests when a therapeutically equivalent generic is preferred: Provider must provide a documented medical reason the preferred generic formulation cannot be used _____ ○ For generic requests when a therapeutically equivalent brand is preferred: Provider must provide a documented medical reason the preferred brand formulation cannot be used _____ ○ For non-preferred dosage or formulation requests: Provider must provide a documented medical reason the preferred dosage or formulation cannot be used _____ 	

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*: _____ **Date:** _____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**

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