15 Earhart Drive, Suite 101, Amherst, NY 14221

MULTIPLE SCLEROSIS AUTHORIZATION/ RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name	Today's Date
Date of birth: Sex: Weight:	Prescriber / Hospital/Clinic
Home Phone Number	Phone Number / Fax Number
Home Address / City / State / Zip	Address / City / State / Zip
Allergies: Member's Insurance ID:	Notes:

DRUG SELECTION AND STATEMENT OF MEDICAL NECESSITY

☐ **AUTHORIZATION** ☐ **RE-AUTHORIZATION**

Primary Diagnosis: ☐RRMS ☐SPMS ☐PPMS ☐PRMS

ICD10 CODE:______________________________________

Number of relapses in past year? ______________________

HX of tried and failed therapies:

DRUG NAME: ***PLEASE INCLUDE THE FOLLOWING***

☐**AUBAGIO** DOSE:_________________FREQUENCY:___________________

-Is patient currently receiving an ABCR drug or other immunosuppressant therapy? ☐ Yes ☐ No

(Cellcept, Azathioprine, mercaptopurine or methotrexate)

-Is patient currently on a leflunomide treatment? ☐ Yes ☐ No

PPD/CXR test results and date:____

-Current Blood Pressure:____

☐CBC, Liver Transaminase, and Serum bilirubin

-For woman of childbearing potential, agreement to use effective contraception ☐ Yes ☐ No

☐**AVONEX:** Dose:_________________ Frequency:___________________

☐ **BETASERON:** Dose_________________ Frequency_________________

☐ **COPAXONE:** DOSE:___________________ Frequency:________________

☐ **EXTAVIA:** Dose:______________ Frequency:____________________

☐**REBIF:** DOSE:______________FREQUENCY:_________________

-Is patient currently receiving concurrent fingoliond therapy? ☐ Yes ☐ No

☐ **GLATOPA:** DOSE:______________FREQUENCY:_________________

☐ **GILENYA:** **DOSE:**_________________**FREQUENCY:**______________________

- ☐ First dose administered and observed for at least 6 hours after administered for bradycardia
- ☐ CBC obtained within last 6 months
- ☐ Liver transaminase
- ☐ Serum bilirubin
- ☐ Baseline ophthalmologic exam
- ☐ Documentation that ECG will be obtained prior to dosing and at end of the observation period.
- ☐ Evidence of varicella zoster virus
- ☐ Contraception for childbearing women
- ☐ Patient is not currently receiving ABCR or immunosuppressant therapy
- ☐ If received Tysabri in last 6 months, a washout period has elapsed.
- ☐ Documentation that the Risk Evaluation and Mitigation Program (REMS) information was discussed with the patient.

-Document tolerance to medication for Annual reauthorization (please attach)

☐**PLEGRIDY:** **DOSE:**_________________**FREQUENCY:**____________________

☐**TECFIDERA:** **DOSE:**_________________**FREQUENCY:**______________________

-Baseline CBC with Lymphocyte count _________ Date________________________

-Document tolerance to medication for Annual reauthorization (PLEASE ATTACH)

-Document tolerance to medication and repeat CBC with Lymphocyte count for Annual reauthorization

☐**TYSABRI:** **DOSE:**_________________**FREQUENCY:**______________________

- ☐ Inadequate response to Avonex, Rebif, Betaseron or Copaxone
- ☐ Patient is not receiving concurrent immunosuppressant therapy
- ☐ If received fingolimod therapy in the last 6 months, a washout period has elasped
- ☐ Medication will be administered in a Touch prescribing program

☐**OCREVUS:** **DOSE:**_________________**FREQUENCY:**______________________

☐**OTHER:** ____

DOSE:_________________**FREQUENCY:**___________________________

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