reliance|rx℠
45 Earhart Drive, Suite 110, 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 Needed	
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:		Office Phone #:	Office Fax Number:
Member's Insurance ID:		Office Contact:	

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
*Nurse teaching through MS One to ONE 1-855-676-6326

☐**AVONEX:**
Dose:_____**Frequency:**_____
*Nurse teaching visit through MS Active Source 1-800-456-2255

☐ **BETASERON:**
Dose_____**Frequency**_____
*Nurse teaching visit through MS Pathways 1-800-788-1467

☐ **COPAXONE:**
DOSE:_____Frequency:_____
*Nurse teaching visit through Shared Solutions 1-800-887-8100

☐ **EXTAVIA:** **Dose:**_____ **Frequency:**_____
*Nurse teaching visit through Extavia Support 1-866-925-2333

☐**REBIF:** **DOSE::**_____**FREQUENCY:**_____
-Is patient currently receiving concurrent fingoliond therapy? ☐ Yes ☐ No
*Nurse teaching visit through MS Lifelines 1-877-447-3243

☐ **GLATOPA:** **DOSE:**_____**FREQUENCY:**_____
*Nurse teaching visit through Glatopa Care 1-855-452-8672

DRUG NAME: ***Please include the following below:**

☐ **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)

☐ OCREVUS: DOSE:_____FREQUENCY:_____

☐**PLEGRIDY:** **DOSE:**_____**FREQUENCY:**_____
*Nurse teaching visit through MS Active Source 1-800-456-2255

☐**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

☐ OTHER:_____

DOSE:_____FREQUENCY:_____