Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
2024 PRIOR AUTHORIZATION REQUEST FORM

Multiple Sclerosis Agents

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the request for a renewal of prior authorization for the drug previously approved?

☐ Yes ☐ No

Q2. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q3. Is the patient prescribed a dose that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the patient age-appropriate for the requested drug according to the Food and Drug Administration (FDA)- approved package labeling, nationally recognized compendia, or peer-reviewed literature?

☐ Yes ☐ No

Q5. Does the patient have a history of a contraindication to the requested drug?

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☐ Yes ☐ No

Q6. Is the requested drug being prescribed by one of the following: A) neurologist, or B) physical medicine and rehabilitation (PM&R) specialist (for Ampyra/dalfampridine only)?

☐ Yes ☐ No

Q7. Is the requested drug Mavenclad (cladribine)?

☐ Yes ☐ No

Q8. Does the patient have documentation of recent lymphocyte count within recommended limits according to the Food and Drug Administration (FDA)-approved package labeling before initiating the first treatment course?

☐ Yes ☐ No

Q9. Is the requested drug Ampyra or dalfampridine?

☐ Yes ☐ No

Q10. Does the patient have motor dysfunction on a continuous basis that impairs the ability to complete instrumental activities of daily living (IADL's) or activities of daily living (ADL's)?

☐ Yes ☐ No

Q11. Is the requested drug generic dalfampridine?

☐ Yes ☐ No

Q12. Is the requested drug fingolimod?

☐ Yes ☐ No

Q13. Does the patient have a comorbid heart condition?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q14. Has the patient experienced any of the following: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalizing or Class III or IV heart failure?

☐ Yes ☐ No

Q15. Is the requested drug Kesimpta (ofatumumab)?

☐ Yes ☐ No

Q16. Does the patient have an active hepatitis B infection?

☐ Yes ☐ No

Q17. Is the requested drug Ocrevus (ocrelizumab)?

☐ Yes ☐ No

Q18. Does the patient have an active hepatitis B infection?

☐ Yes ☐ No

Q19. Is the requested drug a non-preferred agent?

☐ Yes ☐ No

Q20. Is the requested drug Zeposia (ozanimod)?

☐ Yes ☐ No

Q21. Does the patient have severe untreated sleep apnea?

☐ Yes ☐ No

Q22. Will the patient be taking a monoamine oxidase (MAO) inhibitor while taking Zeposia (e.g. selegiline, phenelzine)?

☐ Yes ☐ No

Q23. Does the patient have a comorbid heart condition?

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Patient Name:	Prescriber Name:

☐ Yes ☐ No

Q24. Has the patient experienced any of the following: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalizing or Class III or IV heart failure?

☐ Yes ☐ No

Q25. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred multiple sclerosis agents approved for the patient's diagnosis?

☐ Yes ☐ No

Q26. Does the patient have a current prescription (within the past 90 days) for the same non-preferred multiple sclerosis agent OR if the dosing interval exceeds 90 days, is the patient receiving treatment with the same nonpreferred multiple sclerosis agent and will continue therapy at a dosing interval supported by FDA-approved package labeling, nationally\ recognized compendia, or peer-reviewed literature (Does not apply to nonpreferred brands when the therapeutically equivalent generic, interchangeable biosimilar, or unbranded biologic is preferred or to nonpreferred generics, interchangeable biosimilars, or unbranded biologics when the therapeutically equivalent brand, interchangeable brand, or brand biologic product is preferred)?

☐ Yes ☐ No

Q27. Is the requested drug being prescribed by one of the following: A) neurologist, or B) physical medicine and rehabilitation (PM&R) specialist (for Ampyra/dalfampridine only)?

☐ Yes ☐ No

Q28. Is the patient prescribed a dose that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q29. Does the patient have a history of a contraindication to the requested drug?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q30. Have all potential drug interactions been addressed by the prescriber by one of the following: A) Discontinuation of the interacting drug, B) Dose reduction of the interacting drug, OR C) Counseling the beneficiary of the risks associated with the use of both medications when they interact?

☐ Yes ☐ No

Q31. Is the requested drug brand Ampyra (dalfampridine)?

☐ Yes ☐ No

Q32. Does the patient have documentation of improvement in motor function?

☐ Yes ☐ No

Q33. Is the requested drug being used for a diagnosis of a relapsing form of multiple sclerosis?

☐ Yes ☐ No

Q34. Does the patient have documentation of improvement or stabilization of the multiple sclerosis disease course?

☐ Yes ☐ No

Q35. Is the requested drug being used for a diagnosis of primary progressive multiple sclerosis?

☐ Yes ☐ No

Q36. Does the patient continue to benefit from the prescribed multiple sclerosis agent based on the prescriber's professional judgement?

☐ Yes ☐ No

Q37. Is the requested drug Lemtrada (alemtuzumab)?

☐ Yes ☐ No

Q38. Did the patient receive the previous treatment course at least 12 months prior to the requested treatment course with Lemtrada (alemtuzumab)?

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☐ Yes ☐ No

Q39. Does the patient have signs of malignancy or autoimmune disorder?

☐ Yes ☐ No

Q40. Is the requested drug Aubagio (teriflunomide)?

☐ Yes ☐ No

Q41. Does the patient have a diagnosis of severe immunodeficiency, bone marrow disease, or severe, uncontrolled infection?

☐ Yes ☐ No

Q42. Is the requested drug Ocrevus (ocrelizumab)?

☐ Yes ☐ No

Q43. Does the patient have evidence of significant active infection?

☐ Yes ☐ No

Q44. Is the requested drug Mavenclad (cladribine)?

☐ Yes ☐ No

Q45. Does the patient have documentation of recent lymphocyte count within recommended limits according to the Food and Drug Administration (FDA)-approved package labeling before initiating the second treatment course?

☐ Yes ☐ No

Q46. Has the patient exceeded the recommended total number of treatment courses according to the Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q47. Additional Information:

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Patient Name:	Prescriber Name:

Prescriber Signature _____ Date _____

Updated for 2024