pennsylvania
DEPARTMENT OF HUMAN SERVICES

GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

~~Office of Medical Assistance Programs~~
~~Fee-for-Service, Pharmacy Division~~
~~Phone 1-800-537-8862 Fax 1-866-327-0191~~

Geisinger

MULTIPLE SCLEROSIS AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/3/2022)*

Prior authorization guidelines for **Multiple Sclerosis Agents** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger ~~are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.~~

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Beneficiary's weight:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Has the beneficiary been receiving treatment with the requested medication?		☐Yes – *Submit documentation.* ☐No	

INITIAL requests

For a non-preferred Multiple Sclerosis Agent: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred drugs in this class that are approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes ☐No *Submit documentation.*

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Has a relapsing form of MS *(specify)* → ☐clinically isolated syndrome ☐relapsing remitting disease ☐active secondary progressive disease
☐Has primary progressive MS

☐**Request is for AMPYRA/DALFAMPRIDINE:**
- ☐Has motor dysfunction on a continuous basis that impairs the ability to complete activities of daily living (ADLs) or instrumental ADLs
- ☐Has results of recent kidney function tests
- ☐Has a history of seizure

☐**Request is for AUBAGIO (teriflunomide):**
- ☐Has results of recent liver function tests

☐**Request is for GILENYA (fingolimod):**
- ☐Has a comorbid heart condition – describe: _____
- ☐Experienced any of the following in the past 6 months:
  - ☐Myocardial infarction
  - ☐Unstable angina
  - ☐Stroke
  - ☐Transient ischemic attack
  - ☐Decompensated heart failure
  - ☐Class III/IV heart failure

☐**Request is for KESIMPTA (ofatumumab):**

☐ Does not have active hepatitis B virus infection

☐ **Request is for LEMTRADA (alemtuzumab):** Dates of previous treatment course(s): _____

☐ **Request is for MAVENCLAD (cladribine):** Dates of previous treatment course(s): _____

☐ Has results of a recent lymphocyte count

☐ **Request is for MAYZENT (siponimod):**

☐ Has been tested for CYP2C9 variants to determine CYP2C9 genotype

☐ Has a comorbid heart condition – describe: _____

☐ Experienced any of the following in the past 6 months:

☐ Myocardial infarction
☐ Unstable angina
☐ Stroke
☐ Transient ischemic attack
☐ Decompensated heart failure
☐ Class III/IV heart failure

☐ **Request is for OCREVUS (ocrelizumab):**

☐ Does not have active hepatitis B virus infection

RENEWAL requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ **For AMPYRA/DALFAMPRIDINE:**

☐ Experienced an improvement in motor function since starting the requested medication

☐ Has a history of seizure

☐ **For all MS drugs OTHER THAN Ampyra/dalfampridine:**

☐ Has a relapsing form of MS and experienced improvement or stabilization of the MS disease course since starting the requested medication

☐ Has primary progressive MS and continues to benefit from the requested medication

☐ **Request is for AUBAGIO (teriflunomide):**

☐ Has results of recent liver function tests

☐ **Request is for GILENYA (fingolimod):**

☐ Has a comorbid heart condition – describe: _____

☐ Experienced any of the following in the past 6 months:

☐ Myocardial infarction
☐ Unstable angina
☐ Stroke
☐ Transient ischemic attack
☐ Decompensated heart failure
☐ Class III/IV heart failure

☐ **Request is for KESIMPTA (ofatumumab):**

☐ Does not have active hepatitis B virus infection

☐ **Request is for LEMTRADA (alemtuzumab):** Dates of previous treatment course: _____

☐ **Request is for MAVENCLAD (cladribine):** Dates of previous treatment course(s): _____

☐ Has results of a recent lymphocyte count

☐ **Request is for MAYZENT (siponimod):**

☐ Has a comorbid heart condition – describe: _____

☐ Experienced any of the following in the past 6 months:

☐ Myocardial infarction
☐ Unstable angina
☐ Stroke
☐ Transient ischemic attack
☐ Decompensated heart failure
☐ Class III/IV heart failure

☐ **Request is for OCREVUS (ocrelizumab):**

☐ Does not have active hepatitis B virus infection

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

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PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: