AcariaHealth
An envolve Pharmacy Solution

envolve
Pharmacy Solutions

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Multiple Sclerosis
Prior Authorization Form/ Prescription

Date: _____ Date Medication Required:_____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male	☐ Female

Insurance Information (Attach Copies of cards)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone # ( )	Secure Fax #: ( )	Office contact:	

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Primary Diagnosis

Primary ICD-9/ICD-10 Code: _____

☐ Relapsing-remitting multiple sclerosis (RRMS) ☐ Primary-progressive multiple sclerosis (PPMS) ☐ Progressive-relapsing multiple sclerosis (PRMS)
☐ Secondary-progressive multiple sclerosis (SPMS) ☐ 1st- clinical episode ☐ Other_____

Clinical Information ***** Please submit supporting clinical documentation*****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY**; Therapy start date: _____

Complete Blood Count: _____Date: _____ Creatinine clearance: _____ mL/minute Date: _____

1. Does the patient have MRI features consistent with multiple sclerosis? ☐ Yes ☐ No
2. Will the medication be used as monotherapy? ☐ Yes ☐ No
3. Has the patient tried and had an insufficient response to other biologic for MS? ☐ Yes ☐ No If yes, document therapy tried _____
4. For SPMS diagnosis, does the patient experience relapses? ☐ Yes ☐ No

Tysabri

5. Does the patient have a history of PML? ☐ Yes ☐ No
6. Has the patient develop any of the following conditions: herpes encephalitis and meningitis, severe hepatoxicity, Anaphylaxis, JC Virus? ☐ Yes ☐ No

Avonex, Betaseron, Extavia, Rebif

7. Has the patient previously experienced anaphylaxis with interferon therapy? ☐ Yes ☐ No

Gilenya

8. Has the patient experienced any of the following within the last 6 months? ☐ Yes ☐ No
   ☐ Myocardial infarction (MI) ☐ Unstable angina ☐ Stroke
   ☐ Transient ischemic attack (TIA) ☐ Class III or IV heart failure ☐ Decompensated heart failure requiring hospitalization
9. Does the patient have a history or presence of any of the following? ☐ Yes ☐ No
   ☐ Mobitz Type II 2nd degree AV block ☐ 3rd AV degree AV block ☐ Sick sinus syndrome ☐ Severe liver injury
   ☐ Significant reduction in heart rate ☐ Active infection ☐ Posterior Reversible Encephalopathy Syndrome (PRES)
10. Does the patient have a baseline QTc interval ≥500ms? ☐ Yes ☐ No
11. Does the patient have a functioning pacemaker? ☐ Yes ☐ No
12. Is the patient currently receiving treatment with Class Ia or Class III anti-arrhythmic drugs? ☐ Yes ☐ No

Mitoxantrone

13. Left ventricular ejection fraction: _____ % Absolute Neutrophil count: _____ cell/mm^3 Lifetime Mitoxantrone dose: _____ mg/m^2

Aubagio

14. Is the patient currently receiving treatment with leflunomide (Arava)? ☐ Yes ☐ No

Ampyra

15. Does the patient have a history of seizures? ☐ Yes ☐ No
16. Prior to initiating therapy, does/did the patient have sustained walking impairment? ☐ Yes ☐ No
17. Is/was the patient able to walk 25 feet (with or without assistance)? ☐ Yes ☐ No
18. **If continuation of therapy**, has the patient experienced an improvement in walking speed? ☐ Yes ☐ No
19. **If continuation of therapy**, has there been an improvement in an objective measure of walking ability? ☐ Yes ☐ No

Physician's Signature _____ **Date:** _____ ☐ DAW