Premier Health Plan

Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

GILENYA
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Gilenya				
□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Clinical Information

Diagnosis:	Date of Diagnosis:

Please indicate past medication(s) tried and failed

Medication name	Start date	End date	Strength	Frequency	Reason for Failure or Discontinuation
□ Avonex					
□ Copaxone					
□ Betaseron					
□ Extavia					
□ Rebif					
□ Tecfidera					

Does the member have relapsing form of Multiple Sclerosis?	□ Yes □ No
Will the member be observed for 6 hours for signs and symptoms of bradycardia?	□ Yes □ No
Does the member have evidence of active infection?	□ Yes □ No
Did the member have a recent (within the past 6 months) complete blood count (CBC)? If yes, please indicate date:_____	□ Yes □ No
Did the member have a recent (with in the past 6 months) transaminase and bilirubin level? If yes, please indicate date:_____	□ Yes □ No

Member Name:	DOB:	Health Plan ID:

Please be sure to complete and include this page with the 1st page of this form.

Was the member vaccinated against varicella zoster virus (VZV)? If yes, please indicate date:_____	☐ Yes ☐ No
Has the member demonstrated immunity to VZV by VZV antibody serology? If yes, please provide chart documentation of VZV antibody serology.	☐ Yes ☐ No ☐ Chart Notes
Did the member have a baseline ophthalmologic evaluation of the macula? If yes, please indicate date:_____	☐ Yes ☐ No
Did the member have a recent (within 1 month) electrocardiogram (ECG)? If yes, please indicate date:_____	☐ Yes ☐ No
Does the member have Mobitz Type II second- or third-degree atrioventricular (AV) block or sick sinus syndrome? If yes, does the member have a functioning pacemaker?	☐ Yes ☐ No ☐ Yes ☐ No

Please provide the member's baseline QTc interval:_____

Is the member on concomitant therapy with antineoplastic, immunosuppressive therapy, or immune modulating therapies? If yes, please complete below:	☐ Yes ☐ No

Medication	Dose/Strength	Frequency

Is the member on concomitant therapy with any Class I or Class III antiarrhythmic medications? If yes, please complete below:	☐ Yes ☐ No

Medication	Dose/Strength	Frequency

Is this request for a reauthorization? ☐ **Yes** ☐ **No**

If yes, please include the following documentation:

- ☐ Documentation showing member's disease has stabilized
- ☐ Documentation of no active infection
- ☐ Documentation of 3-month follow-up ophthalmologic evaluation within 3 to 4 months of starting therapy, including date.
- ☐ Documentation that the member is *NOT* on concomitant therapy with antineoplastic, immunosuppressive, or immune modulating therapies.
- ☐ Documentation that the member CBC and transaminase/bilirubin levels are being monitored consistently.

Please provide any additional information which should be considered in the space below: