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

AUBAGIO
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

Medication:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Aubagio	□ 7 mg Tablet □ 14 mg Tablet			
□ 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:

Does the member have relapsing form of Multiple Sclerosis? □ Yes □ No
Does the member have severe hepatic impairment? □ Yes □ No
Does the member have evidence of active infection? □ Yes □ No
Has the member previously tried an interferon product (Avonex, Betaseron, Extavia, Rebif, Copaxone or Tecfidera)? □ Yes □ No

Product	Trial Dates	Reason for Failure

Is the member on concomitant therapy with antineoplastic, immunosuppressive therapy, or immune modulating therapies? □ Yes □ No

Medication	Dose/Strength	Frequency

Has the member had the following labs within the **past 6 months**?

Complete Blood Count (CBC)? □ Yes □ No Date:_____
Transaminase and Bilirubin level? □ Yes □ No Date:_____
PPD (tuberculin) test □ Positive □ Negative Date:_____

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

Female Members	If the member is of childbearing potential, has she had a baseline (within 1 month) negative pregnancy test prior to initiation of therapy?	☐ Yes ☐ No Date:_____
	If the member is of childbearing potential, is she currently using reliable contraception during treatment?	☐ Yes ☐ No

If this request is for <u>reauthorization</u>, please include the following documentation:

☐ Documentation showing members disease has stabilized	☐ Documentation of no active infection
☐ Documentation that the member is <u>NOT</u> on concomitant therapy with antineoplastic, immunosuppressive, or immune modulating therapies.	☐ Documentation that the member's transaminase/bilirubin levels are being monitored consistently.

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