

AUBAGIO Prior Authorization Form

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| <input type="checkbox"/> Standard Request (72 hours)
<input type="checkbox"/> Expedited Request (24 hours) | If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received. |
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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: Aubagio	Strength: <input type="checkbox"/> 7 mg Tablet <input type="checkbox"/> 14 mg Tablet	Directions:	Quantity Dispensed:	Day Supply:
<input type="checkbox"/> New medication <input type="checkbox"/> 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 a relapsing form of Multiple Sclerosis? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have severe hepatic impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have evidence of active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member previously tried at least one other medication for MS (please list below)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient pregnant (if of childbearing age, please provide negative pregnancy test result)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<u>Product</u>	<u>Trial Dates</u>	<u>Reason for Failure</u>
Is the member on concomitant therapy with antineoplastic, immunosuppressive therapy, or immune modulating therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<u>Medication</u>	<u>Dose/Strength</u>	<u>Frequency</u>
Has the member had the following labs within the past 6 months ?		
Complete Blood Count (CBC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Transaminase and Bilirubin level?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
PPD (tuberculin) test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	Date: _____

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