Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

GILENYA
Prior Authorization Form

□ Standard Request (72 hours) □ 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.

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	0.5 mg			
□ 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 a 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

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 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:_____	
Does the member have pre-existing lung disease, such as asthma or COPD? If yes, please provide a spirometric evaluation of respiratory function and evaluation of diffusion lung capacity for carbon monoxide	☐ Yes ☐ No ☐ Chart Notes
Did the member recently (in the past 6 months) experience a myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III/IV heart failure?	☐ Yes ☐ No
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 improved and/or 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 CBC and transaminase/bilirubin levels are being monitored consistently.

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