04/18/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Multiple Sclerosis Agents (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at 1-855-684-5250.
Please contact Aetna Better Health Illinois Medicaid at 1-866-212-2851 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Multiple Sclerosis Agents (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Aubagio (teriflunomide) Avonex (interferon beta-1a) Betaseron (interferon beta-1b)
Copaxone(glatiramer) Extavia (interferon beta-1b) Gilenya (fingolimod)
Mitoxantrone Rebif (interferon beta-1a) Tecfidera (dimethyl fumarate)
Quantity _____ Frequency _____ Strength _____
Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of multiple sclerosis? Y N

   [If no, no further questions.]

2. Is the requested drug prescribed by or in consultation with a neurologist? Y N

   [If no, no further questions.]

3. Is the patient 18 years of age or older? Y N

[If no, no further questions.]

4. Is the request for Gilenya, Tecfidera, or Aubagio? Y N

   [If no, skip to question 6.]

5. Has the patient failed a compliant regimen of two formulary medications such as Avonex, Rebif, Betaseron, Extavia or Copaxone? Y N

   [No further questions.]

6. Is the request for mitoxantrone? Y N

   [If no, no further questions.]

7. Has the patient received a cumulative dose of mitoxantrone greater than 140 mg/m2? Y N

   [If yes, no further questions.]

8. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If yes, skip to question 11.]

9. Has the patient failed a compliant regimen of Avonex, Rebif, Betaseron, Extavia, or Copaxone? Y N

   [If no, no further questions.]

10. Has the patient failed a compliant regimen of Tysabri for 6 months? Y N

    [If no, no further questions.]

11. Is there documentation to support that the following will be done prior to each dose? Y N

    Assessment for cardiac signs and symptoms by history, physical examination and ECG. \ Quantitative reevaluation of LVEF using the same methodology that was used to assess baseline LVEF. \ Confirmation that patient has not received a cumulative dose greater than 140mg/m2.

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date