MOLINA HEALTHCARE

Request for Prior Authorization

Iowa Health Link IOWA HHS Hawki Iowa HHS

Provider Help Desk
1 (844) 236-1464

MULTIPLE SCLEROSIS AGENTS-ORAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

For patients initiating therapy with a preferred oral multiple sclerosis agent, a manual prior authorization (PA) is not required if a preferred injectable interferon or non-interferon is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided:

1. **A diagnosis of relapsing forms of multiple sclerosis, and**
2. **Request must adhere to all FDA approved labeling, including indication, age, dosing, contraindications, and warnings and precautions; and**
3. **Documentation of a previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis.**

Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent.
The required trial may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred

- ☐ Aubagio
- ☐ Dimethyl Fumarate
- ☐ Gilenya

Non-Preferred

- ☐ Bafiertam
- ☐ Fingolimod
- ☐ Mavenclad
- ☐ Mayzent
- ☐ Ponvory
- ☐ Tascenso ODT
- ☐ Tecfidera
- ☐ Vumerity
- ☐ Zeposia

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Treatment failure with a preferred interferon or non-interferon:

Trial Drug Name & Dose: _____ Trial Dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies: _____

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Requests for non-preferred oral multiple sclerosis agents:

Document trial of preferred oral multiple sclerosis agent:

Drug Name & Dose_____ Trial Dates:_____

Failure Reason_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*