Avera Health Plans

Preauthorization Request Form

[Multiple Sclerosis (MS) therapies only]

Please complete each section of this form. Incomplete forms may be returned to sender for additional information. NOTE: For your patient to receive the lowest out-of-pocket costs, use in-network providers unless preauthorization is obtained. Decisions are based on eligibility, benefit determination and medical necessity.

Member name: _____ Date of Birth: _____

Member ID Number: _____ Group Number: _____

NPI number of administering facility: _____ Requested start date: _____

Drug (pharmacy benefit preferred drugs listed)

Oral drugs

- ☐ Aubagio (teriflunomide)
- ☐ Gilenya (fingolimod)
- ☐ Mayzent (simponimod)
- ☐ Mavenclad (cladribine)
- ☐ Dimethyl fumarate
- ☐ Zeposia (ozanimod)
- ☐ Bafiertam (monomethyl fumarate)

Self-injectable drugs

- ☐ Avonex (interferon beta-1a)
- ☐ Betaseron (interferon beta-1b)
- ☐ Copaxone (glatiramer)
- ☐ Extavia (interferon beta-1b)
- ☐ glatiramer
- ☐ Glatopa (glatiramer)
- ☐ Plegridy (peginterferon beta-1a)
- ☐ Rebif (interferon beta-1a)
- ☐ Kesimpta (ofatumumab)
- ☐ Other: _____

Dose & Schedule Requested: _____

HCPCS code(s), please list all that apply (if applicable): _____

Drug (medical benefit drugs listed)

- ☐ Lemtrada (alemtuzumab)
- ☐ Ocrevus (ocrelizumab)
- ☐ Tysabri (natalizumab)
- ☐ Other: _____

Dose & Schedule Requested: _____

HCPCS code(s), please list all that apply (if applicable): _____

Indication

ICD code(s), please list all that apply: _____

- ☐ Multiple Sclerosis
  - ☐ Relapse Remitting ☐ Primary Progressive ☐ Secondary Progressive ☐ Clinically Isolated Syndrome
- ☐ Other: _____

Clinical information

☐ Initial therapy ☐ Continuation of therapy (see below)

For initial therapy, please complete questions below.

1. Is the member greater than or equal to 18 years of age? Yes ☐ No ☐
2. Prior to initiating therapy, has patient received a baseline MRI? Yes ☐ No ☐

3. Will the medication be used as monotherapy and avoid combination with any other disease modifying therapy (DMT) medication? Yes ☐ No ☐

   If "No" please provide clinical rationale as to why multiple DMT therapies are clinically necessary: _____

4. Is the medication prescribed by, or in consultation with, a neurologist? Yes ☐ No ☐

5. Does the member have a documented contraindication (per individual product FDA label) that would result in member not being eligible for the requested medication? Yes ☐ No ☐

   Drug-specific clinical contraindications
   Aubagio (teriflunomide): severe hepatic impairment
   Gilenya (fingolimod):
   - Class III or IV heart failure
   - Concomitant Class Ia or Class III anti-arrhythmic drugs
   - Second-degree or third-degree atrioventricular block (history or current), unless the patient has a functional pacemaker
   - Myocardial infarction, decompensated heart failure requiring hospitalization, stroke, TIA, or unstable angina within the last 6 months
   - QTc interval at baseline 500 milliseconds or greater
   - Sick-sinus syndrome (history or current), unless the patient has a functional pacemaker

   Mayzent (simponimod):
   - Class III or IV heart failure
   - CYP2C9*3/*3 genotype
   - Second-degree or third-degree atrioventricular block (history or current), unless the patient has a functional pacemaker
   - Myocardial infarction, decompensated heart failure requiring hospitalization, stroke, TIA, or unstable angina within the last 6 months
   - Sick-sinus syndrome (history or current), unless the patient has a functional pacemaker

   Tysabri (natalizumab): progressive multifocal leukoencephalopathy (PML)

For continuation of therapy, has the patient completed an annual clinical evaluation and effectiveness clearly documented? Yes ☐ No ☐

If "No" please provide clinical rationale as to why the requested drug should be deemed medically necessary for continuation:

_____

NOTE: Clinical effectiveness established based on the use of drug samples that bypasses policy requirements is not considered a prerequisite for continued coverage. Additionally, prior coverage of a drug under a previous insurance carrier is not a prerequisite for continued coverage under the Health Plans.

Provider Name: _____ Office/Facility Name: _____

Person completing the form: _____ Form Completion Date: _____

Person reviewing the form: _____ Form Review Date: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Determination of medical necessity requires the submission of clinical documentation.

☐ Clinical documentation is available in the Avera electronic medical record for review.
Please list date(s) of pertinent records: _____

☐ Clinical documentation is not available in the Avera electronic medical record for review. Pertinent clinical records for the previous 12 months are attached for review.

Final determination will be faxed to the prescriber. Final determination will be mailed to the member.

IMPORTANT NOTICE*:* This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim. If you have questions about your benefits, please contact Avera Health Plans Customer Care team at 605-322-4545 or toll-free at 1-888-322-2115. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

Fax this completed form to Avera Health Plans at **1-800-269-8561** or send a secure email to Pharmacy@AveraHealthPlans.com.