



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecure-forproviders/pharmacy

Multiple Sclerosis (MS) Agents Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information									
Member Name (first & last):		Date of Birth:		Gender:		Height:			
				<input type="checkbox"/> Male <input type="checkbox"/> Female					
Member ID:		City:		State:		Weight:			
Prescribing Provider Information									
Provider Name (first & last):		Specialty:		NPI#		DEA#			
Office Address:		City:		State:		Zip Code:			
Office Contact:			Office Phone			Office Fax:			
Dispensing Pharmacy Information									
Pharmacy Name:			Pharmacy Phone:			Pharmacy Fax:			
Requested Medication Information									
Preferred Agents:		<input type="checkbox"/> Copaxone 20mg		<input type="checkbox"/> Betaseron		<input type="checkbox"/> Avonex			
		<input type="checkbox"/> Gilenya		<input type="checkbox"/> Glatopa 40mg		<input type="checkbox"/> Rebif / Rebidose			
Non-Preferred Agent:		Other, Please Specify:							
		Was there inadequate response, intolerable side effects OR contraindication to 2 formulary agents, one of which was an interferon or glatiramer acetate?				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No			ICD-10 Code:		Diagnosis:				
What medication(s) have been tried and failed for the diagnosis?									
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Initial request <input type="checkbox"/> Continuation of therapy			
<input type="checkbox"/> CONTINUATION of therapy requests ONLY:									
Was documentation AND lab results submitted supporting response to TX AND no serious toxicity as result of TX?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Are the required initial therapy tests completed AND continuously monitored as clinically appropriate? (LVEF, CBC, ANC, ECG, immunoglobulins level, contraception use for females of reproductive potential)		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Directions for Use:			Strength:			Dosage Form:			
			Quantity:		Day Supply:		Duration of Therapy/Use:		
Turn-Around Time for Review									
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.						
			Signature: _____						
Clinical Information									
Have other disease modifying MS therapies (not including Ampyra) been D/C'd OR have been D/C'd?						<input type="checkbox"/> Yes <input type="checkbox"/> No			
INJECTABLE AGENTS									
<input type="checkbox"/> Copaxone 40mg		<input type="checkbox"/> Avonex		<input type="checkbox"/> Glatopa 20mg glatiramer acetate		<input type="checkbox"/> Extavia		<input type="checkbox"/> Rebif/Rebidose	
Does member have clinically isolated syndrome suggestive of MS (experienced 1 st clinical episode AND MRI features consistent with MS)?			<input type="checkbox"/> Yes <input type="checkbox"/> No		Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> Betaseron		<input type="checkbox"/> Plegridy			
Does member have clinically isolated syndrome suggestive of MS (experienced 1 st clinical episode AND MRI features consistent with MS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ORAL AGENTS					
<input type="checkbox"/> Aubagio					
Is diagnosis clinically isolated syndrome suggestive of MS (experienced 1 st clinical episode AND MRI features consistent with MS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is diagnosis relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is member FEMALE of reproductive potential?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is FEMALE member pregnant?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
Will FEMALE member be using effective contraception during treatment?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
The following LABS have been completed within last SIX months:				<input type="checkbox"/> CBC	<input type="checkbox"/> LFTs and bilirubin
				<input type="checkbox"/> Tuberculin skin test	
<input type="checkbox"/> Bafiertam					
Is the diagnosis relapsing form of MS (for example, relapsing-remitting or active secondary progressive MS)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have clinically isolated syndrome suggestive of MS (for example, experienced 1 st clinical episode and MRI features consistent with MS)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was baseline (within 3 months) MRI scan obtained prior to starting TX course due to risk of PML?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there history of either varicella vaccine series OR zoster vaccine series if 50 years of age or older?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
The following labs have been completed within past 6 months:		<input type="checkbox"/> CBC and lymphocyte count		<input type="checkbox"/> LFTs and bilirubin levels	
<input type="checkbox"/> Gilenya					
Is diagnosis clinically isolated syndrome suggestive of MS (experienced 1 st clinical episode AND MRI features consistent with MS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Labs have been completed within past 6 months:		<input type="checkbox"/> CBC	<input type="checkbox"/> LFTs and bilirubin	<input type="checkbox"/> ECG	<input type="checkbox"/> Ophthalmic examination
Is there history of either varicella vaccine series OR zoster vaccine series if 50 years of age or older?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Documented history of ANY of the following:		<input type="checkbox"/> MI - Unstable Angina – stroke – TIA - Decompensated HF requiring hospitalization OR Class III/IV HF within past 6 months			
		<input type="checkbox"/> Corrected QTc ≥500 msec			
		<input type="checkbox"/> HX of Mobitz type II (2 nd OR 3 rd degree AV block) OR sick sinus syndrome, unless there is a pacemaker			
		<input type="checkbox"/> Treatment with Class Ia OR Class III anti-arrhythmic drugs			
<input type="checkbox"/> Mayzent					
Is diagnosis clinically isolated syndrome suggestive of MS (experienced 1 st clinical episode AND MRI features consistent with MS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was member tested for CYP2C9 variants to determine CYP2C9 genotype?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member positive for CYP2C9*3/*3?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Labs have been completed within past 6 months:		<input type="checkbox"/> CBC	<input type="checkbox"/> LFTs and bilirubin	<input type="checkbox"/> ECG	<input type="checkbox"/> Ophthalmic exam
Is there history of either varicella vaccine series OR zoster vaccine series if 50 years of age or older?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Documented history of ANY of the following:		<input type="checkbox"/> MI - Unstable Angina – Stroke – TIA - Decompensated HF requiring hospitalization OR Class III/IV HF within past SIX months			
		<input type="checkbox"/> History of Mobitz type II (2 nd OR 3 rd degree AV block) OR sick sinus syndrome, unless member has pacemaker			
<input type="checkbox"/> Mavenclad					
Does member have clinically isolated syndrome suggestive of MS (experienced 1 st clinical episode AND have MRI features consistent with MS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was baseline (within 3 months) MRI scan obtained prior to starting TX course due to risk of PML?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there infection with HIV AND active chronic infections (Hepatitis OR TB) OR breastfeeding (during TX OR for 10 days after last dose)?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is member a FEMALE of reproductive potential?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the FEMALE member pregnant?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A

Will the FEMALE member be using effective contraception during treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Has the member received the lifetime maximum of 2 courses (4 cycles) of therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Zeposia				
Is the diagnosis of relapsing form of MS (for ex relapsing-remitting or active secondary progressive MS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is there clinically isolated syndrome suggestive of MS (for example experienced a 1 st clinical episode and have MRI features consistent with MS)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any ONE of the following is present:	<input type="checkbox"/> History (within last 6 months) of MI, UA, stroke, TIA, decompensated heart failure requiring hospitalization OR NYHA Class III/IV heart failure			
	<input type="checkbox"/> History OR presence of Mobitz Type II 2 nd OR 3 rd degree AV block, sick sinus syndrome OR sino-atrial block (unless there is a functioning pacemaker)			
	<input type="checkbox"/> Severe untreated sleep apnea			
ALL the following labs were completed within the last 6 months:		<input type="checkbox"/> CBC	<input type="checkbox"/> LFTs and bilirubin levels	
		<input type="checkbox"/> ECG	<input type="checkbox"/> Ophthalmic examination	
Is there HX of either varicella vaccine series OR zoster vaccine series if 50 years of age or older?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was baseline (past 3 months) MRI scan obtained prior to starting TX course due to risk of PML?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is member a FEMALE of reproductive potential?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the FEMALE member pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Will the FEMALE member be using effective contraception during treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Tecfidera	<input type="checkbox"/> Vumerity			
Does member have clinically isolated syndrome suggestive of MS (experienced 1 st clinical episode AND have MRI features consistent with MS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
The following LABS have been completed within last SIX months:		<input type="checkbox"/> CBC	<input type="checkbox"/> LFTs and bilirubin	
INFUSIONS				
<input type="checkbox"/> Ocrevus				
Was member screened for Hepatitis B?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have active Hepatitis B infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does member have clinically isolated syndrome suggestive of MS (experienced 1 st clinical episode AND have MRI features consistent with MS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is diagnosis of Primary-Progressive MS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> Lemtrada				
Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will treatment exceed FIVE days the first year, AND THREE days the 2nd year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
The following been completed prior to starting TX?	<input type="checkbox"/> CBC		<input type="checkbox"/> Necessary immunizations	<input type="checkbox"/> Serum creatinine levels
	<input type="checkbox"/> History of either varicella vaccine series OR zoster vaccine series if 50 years of age or older			
	<input type="checkbox"/> Screened for TB AND If screening positive, TX was received		<input type="checkbox"/> Thyroid Function Test	
<input type="checkbox"/> Tysabri				
Is diagnosis clinically isolated syndrome suggestive of MS (experienced 1 st clinical episode AND MRI features consistent w/MS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is diagnosis of relapsing form of MS (relapsing-remitting OR active secondary progressive MS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anti-JCV antibody test (ELISA [enzyme-linked immunosorbent assay]) been completed?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Mitoxantrone				
Member has ANY of the following MS diagnosis:	<input type="checkbox"/> Worsening relapsing-remitting to reduce neurologic disability AND/OR frequency of clinical relapse		<input type="checkbox"/> Secondary (chronic) progressive	<input type="checkbox"/> Progressive relapsing <input type="checkbox"/> Primary progressive
Was cumulative lifetime dose exceeded?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
The following labs have been completed within last SIX months:	<input type="checkbox"/> LVEF >50% (not below lower limit of normal)		<input type="checkbox"/> ANC >1500 cells/mm3	
	<input type="checkbox"/> CBC		<input type="checkbox"/> LFTs	

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.