reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

MULTIPLE SCLEROSIS AUTHORIZATION / RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name: Today's Date: Date Needed:	
Date of birth: Sex: Weight:	Prescriber: Hospital/Clinic:
Home Phone Number: ( )	Phone Number: ( ) Fax Number: ( )
Home Address: City: State: Zip:	Address: City: State: Zip:
Payor: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions Insurance ID: Group Number:	Office Specialty: Allergies: Is patient self-injecting? ☐ Yes ☐ No

DRUG SELECTION AND STATEMENT OF MEDICAL NECESSITY

☐ AUTHORIZATION ☐RE-AUTHORIZATION Primary Diagnosis: ☐RRMS ☐SPMS ☐PPMS ☐PRMS ☐CIS

Drug Requested: _____ ICD10 Code:_____

Dose: _____ Frequency: _____ Will patient be discontinuing current treatments? ☐ Yes ☐ No

Please list all medications this patient has tried for the above diagnosis:

_____

☐DALFAMPRIDINE

☐ Medication is being requested to improve walking speed? ☐ Yes ☐ No

☐Baseline timed 25-foot walk _____ Date: _____

☐Serum Creatinine _____ Date: _____

☐ current weight_____ Date: _____

☐Is patient wheelchair bound? ☐ Yes ☐ No

☐ Is this patient able to ambulate with or without the use of a walking device? ☐ Yes ☐ No

☐Patient does not have a history of seizure disorder. ☐Yes ☐No

FOR RE-AUTHORIZATION

☐ current timed 25-foot walk _____ Date: _____

☐ Serum Creatinine _____ Date: _____

☐ current weight_____ Date: _____

☐ Patient is not wheelchair bound and able to ambulate with or without a walking device? ☐ Yes ☐ No

☐ Patient has not been diagnosed with a seizure disorder. ☐ Yes ☐ No

☐AUBAGIO

Please submit a copy of the following test results obtained within the past 6 months:

☐CBC

☐Liver Transaminase and serum bilirubin

☐Blood pressure: _____ Date: _____

☐baseline tuberculosis test result: _____Date: _____

If test is positive:

-Has patient been evaluated for latent tuberculosis before initiating Aubagio therapy? ☐Yes ☐No

☐ **If** female patient of childbearing potential, patient has agreement to use effective contraception during Aubagio treatment? ☐ Yes ☐ No

☐ Is patient currently receiving an ABCR drug or other immunosuppressant therapy? ☐ Yes ☐ No

☐ Is patient currently on a leflunomide treatment? ☐ Yes ☐ No

FOR RE-AUTHORIZATION

☐ Patient is tolerating medication without any adverse effects

☐ Please submit updated lab values and test results

☐ Provide documentation of patient response

☐AVONEX /GLATIRAMER /PLEGRIDY/ REBIF/ GLATOPA/ EXTAVIA/ COPAXONE

☐ Is patient receiving concurrent fingolimod therapy? ☐Yes ☐No

-For Glatopa

☐Has patient tried and failed glatiramer? ☐ Yes ☐ No

☐Does patient have a contraindication to glatiramer? ☐ Yes ☐ No

If yes, please explain:

_____

_____

☐ DIMETHYL FUMERATE OR ☐ TECFIDERA

Please submit a copy of the following test results obtained within the past 6 months prior to starting therapy:

☐ Baseline CBC including lymphocyte count

☐ Baseline AST, ALT, alkaline phosphate and total bilirubin

FOR RE-AUTHORIZATION

☐ Please provide documentation of patient response to therapy

☐ Patient is tolerating medication without any adverse effect ☐ Yes ☐ No

☐ Provide updated CBC including lymphocyte count

☐ KESIMPTA

☐ Has the patient undergone screening for Hepatitis B virus (HBV) and quantitative serum immunoglobulins and there is no active infection? ☐ Yes ☐ No

☐ Will patient receive live-attenuated or live vaccines during treatment and after discontinuation until B-cell repletion? ☐ Yes ☐ No

☐ Female patients of reproductive potential are not pregnant and have been advised to use effective contraception during treatment with Kesimpta and for 6 months after the last treatment of Kesimpta? ☐ Yes ☐ No

FOR RE-AUTHORIZATION

☐Please provide documentation of patient response to therapy

☐ Patient is tolerating medication without any adverse effects

☐ GILENYA

Please submit a copy of the following test results:

☐ CBC (obtained within the past 6 months)
☐ Liver Transaminase
☐ Serum bilirubin
☐ Has patient had a baseline ophthalmologic exam? ☐ Yes ☐ No
☐ Does patient have varicella zoster virus immunity? ☐ Yes ☐ No
☐ Will and ECG be obtained prior to dosing and at end of observation period? ☐ Yes ☐ No
☐ Is patient currently receiving an ABCR drug or other immunosuppressant therapy? ☐ Yes ☐ No
(Cellcept, Azathioprine, mercaptpurine, methotrexate)

☐ If patient was receiving Tysabri, has at least a 6-month washout period elapsed? ☐ Yes ☐ No

-For pediatric patients:
☐ Has patient completed all immunizations in accordance with current immunization guidelines? ☐ Yes ☐ No

-For women of childbearing potential:
☐ Does patient agree to use effective contraception during and for two months after stopping Gilenya treatment? ☐ Yes ☐ No

☐ Will the first dose be administered in the MD office and patient will be observed for at least 6 hours to monitor for bradycardia? ☐ Yes ☐ No

FOR RE-AUTHORIZATION

☐ Patient is tolerating medication without any adverse effects.

☐ Please submit updated lab values/test results/exams with current values
☐ Please provide documentation of patient response

☐ OTHER

NAME: _____

☐ OCREVUS

☐ Ocrevus will be used as monotherapy (not used in combination with other disease-modifying MS therapies) ☐ Yes ☐ No

☐ Documentation submitted confirming that patient has had Hepatitis B virus (HBV) screening.

☐ Will patient receive live-attenuated or live vaccines during treatment and after discontinuation until B-cell repletion? ☐ Yes ☐ No

☐ Patient does not have an active infection and documentation submitted by the health care provider that they will assess the patient for active infection prior to each infusion of Ocrevus ☐ Yes ☐ No

☐ Will the infusion be administered under the close supervision of an experienced healthcare professional with access to appropriate medical support to manage severe reactions such as serious infusion reactions?
☐ Yes ☐ No

FOR RE-AUTHORIZATION

☐ Provide documentation of patient response

☐ Is patient tolerating medication without any adverse effects? ☐ Yes ☐ No

☐ ZEPOSIA

Please submit a copy of the following test results:

☐ Complete Blood Count (CBC) including lymphocyte count
☐ Electrocardiogram (ECG)
☐ Liver function tests (AST, ALT, bilirubin)
☐ Ophthalmic assessment in patients with history of uveitis or macular edema
☐ Varicella zoster virus (VZV) antibody test
If negative, has VZV vaccine been administered? ☐ Yes ☐ No

☐ Females of childbearing potential have been advised of the potential for a serious risk to the fetus and the need to use effective contraception during treatment and for 3 months after stopping Zeposia? ☐ Yes ☐ No

FOR RE-AUTHORIZATION

☐Patient has a documented response to therapy or maintenance of symptoms and is not experiencing any disease progression

☐ Patient is not experiencing any unacceptable toxicity from the medication