Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION BYPASS

Tecfidera® (dimethyl fumarate)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Name ______________________
Address ______________________

Rx

Refer for Multiple Sclerosis Protocol

MD ______________________
Signature ______________________

Name ______________________
Address ______________________

Rx naltrexone 0.5mg
quantity #
sig: 1 capsule daily x 1 week; increase 1 cap weekly to 4.5mg daily
as directed by physician
Dx: MULTIPLE SCLEREOSIS

ICD 10: G 35.

MD ______________________
Signature ______________________

SAMPLE

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone: ___ - ___ - ____	Fax: ___ - ___ - ____

Member Information

Last Name:	First Name
Member ID Number	DOB: __ - __ - ____

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Tecfidera Prior Authorization Form

Initial Therapy **You must answer ALL of the following questions**		
1. Is the medication being prescribed by a neurologist?	Y	N
2. Is the patient 18 years of age or older?	Y	N
3. Does the patient have a diagnosis of relapsing-remitting multiple sclerosis (RRMS)? *Please provide documentation verifying the diagnosis.*	Y	N
4. Has the patient tried and had an inadequate response to a three month trial of Avonex?	Y	N
5. Has the patient had prior treatment with Rebif, Betaseron or Extavia?	Y	N
6. Has the patient tried and had an inadequate response to a three month trial of Copaxone?	Y	N
7. Has the patient had prior treatment with Tysabri?	Y	N
8. Has the patient had a positive anti-JC antibody test?	Y	N
9. Has the patient tried and had an inadequate response to a three month trial of one of the following therapies? **(Please Circle)** • Copaxone • Beta interferon (e.g., Rebif, Avonex, Betaseron, Extavia) • Tysabri	Y	N

Renewal Therapy **You must answer ALL of the following questions**		
1. Is the medication being prescribed by a neurologist?	Y	N

2. Is the patient continuing to have a positive clinical response, and is remission of disease maintained with continued use? *Please provide supporting chart notes.*	Y	N

Please note, not all drugs/diagnoses are covered on all plans.

Comments: ____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

____ _______________________

Prescriber or Authorized Signature **Date**

____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear onn the Cover Page.

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

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PRIOR AUTHORIZATION FORM

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	
DRUG INFORMATION			
Drug Name			
Quantity		**ICD-9**	
Directions		**Duration of Therapy**	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
Medication/Failure Reason:			

IgE:______________

ESR:_______________ **CRP:**_______________ **# Joints:**_______________ **%BSA:**______________

Height:_______________ **Weight:**_______________ **BMI:**_______________

HA1C:_______________ **Hemoglobin:**_______________ **Hematocrit:**_______________ **T-Score:**_____________

Dialysis:_____________ **Long Term Care Facility:**_____________ **Self Injecting:**_____________

Stimulation test:__________/__________ **Growth velocity:**___________ **#Chemotherapy cycles/month:**__________

Mini-Mental Status Test:____________ **Baseline Free testosterone/Total testosterone:**_________/_________

HCV RNA viral load:______________ **Viral Genotype:**_______________ **ALT:**_______________

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	

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