Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Multiple Sclerosis (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Multiple Sclerosis (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

Specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____
Member ID: _____
Member Group No.: _____
Member DOB: _____
Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis:_____ **ICD Code:**_____

Circle the appropriate answer for each question.

1. Is the requested drug prescribed by or in consultation with a neurologist? Y N

   [If no, then no further questions.]

2. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 11.]

3. Is the member having a positive clinical response to the requested medication? Y N

   [If no, then no further questions.]

4. Have documentation and lab results as applicable to support the response to Y N

treatment been submitted (for example, left ventricular ejection fraction [LVEF], complete blood count [CBC], absolute neutrophil count [ANC], electrocardiogram [ECG], etc.)?

[If no, then no further questions.]

5. Is the renewal for Tysabri or Ocrevus? Y N

   [If yes, then no further questions.]

6. Is the renewal for Aubagio, Gilenya, or Tecfidera? Y N

   [If yes, then no further questions.]

7. Is the renewal for Lemtrada? Y N

   [If no, skip to question 9.]

8. Has the member received more than 2 years of treatment with Lemtrada? Y N

   If yes, please provide rationale for continued treatment:

   _____

   [No further questions.]

9. Is the renewal for mitoxantrone? Y N

   [If no, then no further questions.]

10. Has the member received a cumulative lifetime dose of 140 mg/m2? Y N

    [No further questions.]

11. Is this a request for mitoxantrone? Y N

    [If no, skip to question 21.]

12. Is the medication requested for the treatment of worsening relapsing-remitting multiple sclerosis (RRMS) to reduce neurologic disability and/or frequency of clinical relapse? Y N

    [If yes, skip to question 14.]

13. Does the member have a diagnosis of secondary (chronic) progressive MS (SPMS) or progressive relapsing MS (PRMS)? Y N

    [If no, then no further questions.]

14. Has the member had an inadequate response, intolerable side effects, or has a contraindication to 2 formulary agents, one of which must be a formulary

interferon or glatiramer acetate agent? (see formulary for a list of preferred agents)

Note: Examples of treatment failure over 1 year period of using disease-modifying therapies include: A) 1 or more relapses, 2) magnetic resonance imaging (MRI) lesion progression (for example, increase in T1, T2, or gadolinium lesions), and C) worsening disability or Expanded Disability Status Scale (EDSS) score.

List medications tried and description of failure:

_____

[If no, then no further questions.]

15. Will all other multiple sclerosis medications (not including Ampyra) be discontinued before starting mitoxantrone or have they already been discontinued? Y N

    [If no, then no further questions.]

16. Is the member at least 18 years old? Y N

    [If no, then no further questions.]

17. Has the member received a cumulative lifetime dose of 140 mg/m2? Y N

    [If yes, then no further questions.]

18. Has the member had both of the following within the past 6 months: A) left ventricular ejection fraction measured and B) a complete blood count (CBC)? Y N

    [If no, then no further questions.]

19. Was the LVEF (left ventricular ejection fraction) greater than 50 percent (not below the lower limit of normal)? Y N

    [If no, then no further questions.]

20. Did the complete blood count (CBC) show an absolute neutrophil count (ANC) greater than 1500 cells/mm3? Y N

    [No further questions.]

21. Does the member have a diagnosis of a relapsing form of multiple sclerosis (for example, relapsing-remitting multiple sclerosis or secondary progressive multiple sclerosis)? Y N

    [If yes, skip to question 27.]

22. Is this a request for glatiramer acetate 20 mg, Copaxone 40 mg, Glatopa, Y N

Extavia, Rebif/Rebidose, or Avonex for a diagnosis of clinically isolated syndrome suggestive of multiple sclerosis (for example, persons who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with multiple sclerosis)?

[If yes, skip to question 50.]

23. Is this a request for Aubagio for a diagnosis of clinically isolated syndrome suggestive of multiple sclerosis (for example, persons who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with multiple sclerosis)? Y N

[If yes, skip to question 39.]

24. Is this a request for Betaseron for a diagnosis of clinically isolated syndrome suggestive of multiple sclerosis (for example, persons who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with multiple sclerosis)? Y N

[If yes, skip to question 49.]

25. Is this a request for Ocrevus for a diagnosis of primary progressive multiple sclerosis (PPMS)? Y N

[If no, then no further questions.]

26. Has the member been screened for hepatitis B and determined not to have an active hepatitis B infection? Y N

[If yes, skip to question 50.] [If no, then no further questions.]

27. Is the request for a preferred injectable agent? (refer to formulary for a list of preferred agents) Y N

[If yes, skip to question 50.]

28. Is the request for a non-preferred injectable/infused agent? Y N

[If no, skip to question 38.]

29. Is the request for Betaseron or Plegridy? Y N

[If yes, skip to question 49.]

30. Is the request for Lemtrada? Y N

[If no, skip to question 34.]

31. Does the member have human immunodeficiency virus (HIV) infection? Y N

[If yes, then no further questions.]

32. Has the member already received a 2 year course of therapy with Lemtrada (5 days of treatment the first year and 3 days of treatment the second year) or will treatment exceed five (5) days of treatment the first year and three (3) days of treatment the second year? Y N

    [If yes, then no further questions.]

33. Does the member meet all of the following criteria: A) a complete blood count (CBC) and serum creatinine levels have been completed prior to initiating treatment, B) member completed any necessary immunizations at least 6 weeks prior to treatment, and C) member has a history of varicella OR has had the varicella zoster vaccination OR has evidence of immunity (positive antibodies)? Y N

    [If no, then no further questions.] [If yes, skip to question 49.]

34. Is the request for Tysabri? Y N

    [If no, skip to question 36.]

35. Has an anti-JCV (John Cunningham virus) antibody test (ELISA [enzyme-linked immunosorbent assay]) been completed? Y N

    Note: Those with positive anti-JCV antibody have a higher risk for developing progressive multifocal leukoencephalopathy (PML).

    [If yes, go to question 49.] [If no, then no further questions.]

36. Is the request for Ocrevus? Y N

    [If no, then no further questions.]

37. Has the member been screened for hepatitis B and determined not to have an active hepatitis B infection? Y N

    [If yes, skip to question 49.] [If no, then no further questions.]

38. Is the request for Aubagio? Y N

    [If no, skip to question 40.]

39. Have all of the following labs been completed within the last 6 months: A) complete blood count (CBC), B) liver function tests (LFTs) and bilirubin levels, and C) tuberculin skin test? Y N

    [If yes, skip to question 50.] [If no, then no further questions.]

40. Is the request for Gilenya? Y N

[If no, skip to question 47.]

41. Have all of the following labs been completed within the last 6 months: A) complete blood count (CBC), B) liver function tests (LFTs) and bilirubin levels, C) electrocardiogram (EKG) evaluation, and D) ophthalmic examination? Y N

[If no, then no further questions.]

42. Does the member meet any of the following: A) documented history of chicken pox, B) has had the varicella zoster vaccination, or C) has evidence of immunity (positive antibodies)? Y N

[If no, then no further questions.]

43. Has the member experienced any of the following within the last 6 months: A) myocardial infarction, B) unstable angina, C) stroke, D) TIA (transient ischemic attack), or E) decompensated heart failure requiring hospitalization? Y N

[If yes, then no further questions.]

44. Does the patient have a corrected QT (QTc) interval greater than or equal to 500 msec, a history of Mobitz type II (2nd or 3rd degree atrioventricular [AV] block) or sick sinus syndrome? Y N

[If yes, then no further questions.]

45. Does the patient have Class III or IV heart failure? Y N

[If yes, then no further questions.]

46. Is the patient receiving treatment with Class Ia or Class III anti-arrhythmic drugs? Y N

[If yes, then no further questions.] [If no, skip to question 50.]

47. Is the request for Tecfidera? Y N

[If no, then no further questions.]

48. Has the member had a complete blood count, liver function tests (LFTs) and bilirubin levels measured within the past 6 months? Y N

[If yes, skip to question 50.] [If no, then no further questions.]

49. Has the member had an inadequate response, intolerable side effects, or has a contraindication to 2 formulary agents, one of which must be a formulary interferon or glatiramer acetate agent? (see formulary for a list of preferred Y N

agents)

Note: Examples of treatment failure over 1 year period of using disease-modifying therapies include: A) 1 or more relapses, 2) Magnetic resonance imaging (MRI) lesion progression (for example, increase in T1, T2, or gadolinium lesions), and C) worsening disability or Expanded Disability Status Scale (EDSS) score.

List medications tried and description of failure:

_____

[If no, then no further questions.]

50. Will all other multiple sclerosis medications (not including Ampyra) be discontinued before starting the requested medication or have they been already discontinued? Y N

[If no, then no further questions.]

51. Is the member at least 18 years old? Y N

[If yes, then no further questions.]

52. Does the member meet both of the following criteria: A) member is at least 10 years of age, and B) the requested mediation is Gilenya? Y N

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature **Date**