CVS caremark™ {{PANUMCODE}}

MULTIPLE SCLEROSIS

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

PATIENT INFORMATION
Date: {{TODAY}}
Name: {{MEMFIRST}} {{MEMLAST}}
ID: {{MEMBERID}}
Date of Birth: {{MEMBERDOB}}
Request Initiated For: {{DRUGNAME}}

PRESCRIBER INFORMATION
Name: {{PHYFIRST}} {{PHYLAST}}
Office Telephone: {{PHYSICIANPHONE}}
Office Fax: {{PHYSICIANFAX}}
Specialty: _____
NPI#: _____

DRUG PRESCRIBED

Preferred: ❑ Aubagio ❑ Avonex ❑ Betaseron ❑ Copaxone 40mg ❑ Copaxone 20mg ❑ dalfampridine ER ❑ Gilenya ❑ glatiramer 20mg ❑ glatiramer 40mg ❑ Glatopa ❑ Mavenclad ❑ Mayzent ❑ Rebif ❑ dimethyl fumarate ❑ Tysabri ❑ Zeposia ❑ Vumerity ❑ Kesimpta (indicate dose below):

a) Loading dose:
❑ Kesimpta 20mg PFS Quantity and Frequency: _____

b) Maintenance dose:
❑ Kesimpta 20mg PFS Quantity and Frequency: _____

Non-preferred: ❑ Ampyra ❑ Bafiertam ❑ Extavia ❑ Lemtrada ❑ Tecfidera ❑ Ponvory ❑ Other _____

PATIENT DIAGNOSIS & ICD-10 CODE

❑ Relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse)
❑ Primary progressive multiple sclerosis (PPMS)
❑ Clinically isolated syndrome of multiple sclerosis
❑ Other _____

ICD-10: _____

Note: If patient's diagnosis is Crohn's disease or Ulcerative colitis, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.

PREFERRED PRODUCT: ***Complete the section(s) below if non-preferred product(s) are being prescribed.***

1. The preferred products for your patient's health plan are Aubagio, Avonex, Betaseron, Copaxone, dimethyl fumarate, Gilenya, glatiramer, Glatopa, Kesimpta, Mayzent, Ocrevus, Rebif, Tysabri, Vumerity and Zeposia. *If the request is for Extavia, please note that Betaseron and Extavia are the exact same products with different labels and brand names, which are made in the same manufacturing facility.* Can the patient's treatment be switched to a preferred product? ***If Yes, fax a new prescription to the pharmacy and skip to next section.***
   ❑ Yes - Please specify: _____ ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

2. Does the patient have a documented inadequate response or an intolerable adverse event with any of the following preferred products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** Indicate ALL that apply.

❑ Aubagio:	❑ Inadequate response	❑ Intolerable adverse event
❑ Avonex:	❑ Inadequate response	❑ Intolerable adverse event
❑ Betaseron:	❑ Inadequate response	❑ Intolerable adverse event
❑ Copaxone:	❑ Inadequate response	❑ Intolerable adverse event
❑ dimethyl fumarate:	❑ Inadequate response	❑ Intolerable adverse event
❑ Gilenya:	❑ Inadequate response	❑ Intolerable adverse event
❑ glatiramer:	❑ Inadequate response	❑ Intolerable adverse event
❑ Glatopa:	❑ Inadequate response	❑ Intolerable adverse event
❑ Kesimpta:	❑ Inadequate response	❑ Intolerable adverse event
❑ Mayzent:	❑ Inadequate response	❑ Intolerable adverse event
❑ Ocrevus	❑ Inadequate response	❑ Intolerable adverse event
❑ Rebif:	❑ Inadequate response	❑ Intolerable adverse event
❑ Tysabri:	❑ Inadequate response	❑ Intolerable adverse event
❑ Vumerity:	❑ Inadequate response	❑ Intolerable adverse event
❑ Zeposia:	❑ Inadequate response	❑ Intolerable adverse event

❑ No - None of the above

Extavia

3. Given that Betaseron and Extavia are the same products, is there a documented clinical reason that the patient must use Extavia over Betaseron? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

Lemtrada

4. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'. ❑ Yes ❑ No

Tecfidera

5. Does the patient have a documented intolerable adverse event to generic dimethyl fumarate? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

6. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If No, attach supporting chart note(s).*** ❑ Yes ❑ No

ALL REQUESTS (EXCEPT AMPYRA)

1. Is this a request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #3*

2. Has the patient achieved or maintained a positive clinical response by experiencing disease stability or improvement while receiving the requested medication? ❑ Yes ❑ No

3. Is the patient taking the requested medication with any other disease modifying multiple sclerosis (MS) agent? (Note: Ampyra and Nuedexta are not disease modifying.) ❑ Yes ❑ No

DRUG SPECIFIC QUESTIONS

MAVENCLAD

1. How many cycles of Mavenclad has the patient received previously? *Note: Mavenclad is administered based on weight over 4 to 5 days. This 4 to 5 day administration period is a cycle. Two cycles administered three to four weeks apart are a course.* _____ cycle(s) ❑ None

2. Is this a request for continuation of therapy? *If Yes, skip to #4* ❑ Yes ❑ No

3. Has the patient had an inadequate response or was unable to tolerate an alternative drug indicated for the treatment of multiple sclerosis (e.g., Rebif, Tecfidera, Copaxone, etc)? ❑ Yes ❑ No *No further questions*

4. Has the patient received a complete course (two 4-5 day cycles) of Mavenclad in the last 43 weeks? *Note: One course is two 4 to 5 day cycles administered 3 to 4 weeks apart).* ❑ Yes ❑ No

AMPYRA (dalfampridine ER)

1. If brand Ampyra is being prescribed, is the prescriber willing to switch to the generic dalfampridine ER?
   If Yes, fax a new prescription to the pharmacy and skip to #5.
   ❑ Yes - generic dalfampridine ER ❑ No ❑ Generic dalfampridine ER is being requested, *skip to #5*
2. Has the patient failed treatment with the generic medication due to an intolerable adverse event (e.g., rash, nausea, vomiting)? ❑ Yes ❑ No
3. Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)? ❑ Yes ❑ No
4. Was this adverse event documented in the patient's chart? ***ACTION REQUIRED: Documentation is required for approval. Provide SPECIFIC and DETAILED chart documentation including description, date/time, and severity of the adverse event, dosage and duration of generic medication treatment, required intervention (if any), and relevant tests or laboratory data (if any) OR MedWatch form of this trial and failure including the adverse reaction.*** ❑ Yes ❑ No
5. Is this request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #7*
6. Has the patient experienced improvement in walking speed or other objective measure of walking ability since starting therapy with the requested medication? ❑ Yes ❑ No *No further questions*
7. Prior to initiation of therapy with the requested medication, does/did the patient have sustained walking impairment? ❑ Yes ❑ No

LEMTRADA

1. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No
2. How many courses of the requested medication has the patient previously received? _____ courses
   If one course or more (5 doses or more), skip to #4.
3. Has the patient had an inadequate response to two or more drugs indicated for multiple sclerosis?
   ❑ Yes ❑ No *No further questions*
4. Has the patient received the last dose of the previous course of the requested medication at least 12 months prior to the planned date of the first dose of the subsequent treatment course of the requested medication?
   ❑ Yes ❑ No

TYSABRI

1. Will the requested medication be used in combination with any other disease modifying multiple sclerosis (MS) agents (Note: Ampyra and Nuedexta are not disease modifying), immunosuppressants, or tumor necrosis factor (TNF) inhibitors (e.g., adalimumab, infliximab)? ❑ Yes ❑ No
2. *If initiation of therapy,* has the patient been tested for anti-JCV (John Cunningham virus) antibodies?
   ❑ Yes ❑ No
3. What is the prescribed dose and frequency? _____ mg every _____ weeks

BAFIERTAM AND ZEPOSIA

1. Will the requested drug be used in combination with any other disease modifying MS agent? (Note: Ampyra and Nuedexta are not disease modifying.) ❑ Yes ❑ No

Zeposia

2. Is this a request for continuation of therapy? ❑ Yes ❑ No *If No, no further questions*

3. Is the patient experiencing disease stability or improvement while receiving the requested medication?
   ❑ Yes ❑ No

AUTHORIZATION

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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