PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Avonex® (interferon beta 1A)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
☐ Avonex 30 mcg vial
☐ Avonex 30 mcg prefilled syringe
☐ Avonex 30 mcg pen kit

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of relapsing-remitting multiple sclerosis (RRMS), secondary-progressive multiple sclerosis (SPMS), or progressive-relapsing multiple sclerosis (PRMS). (documentation of a multiple sclerosis ICD10 code* within the last 12 months must be submitted to Priority Health)
2. Prescriber is board-certified neurologist or multiple sclerosis physician specialist with experience prescribing MS therapy
3. Patient will not be using in combination with another disease-modifying agent for MS
4. Must first try glatiramer

* Approved ICD10 codes are provided in the Additional Information section

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2019
Last reviewed 07/2020

PriorityHealth

Priority Health Precertification Documentation

A. What condition is this drug being requested for? (documentation of an approved ICD10 code from within the last 12 months must be submitted to Priority Health)

☐ RRMS ☐ SPMS ☐ PRMS

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Is the prescriber a neurologist?

☐ Yes ☐ No

C. Will patient be using in combination with another disease-modifying agent for MS?

☐ Yes, *rationale:* _____

☐ No

D. Please list what other disease modifying treatments for MS the patient has tried:

Drug	Dates	Outcome

Additional information

Approved ICD10 Codes for Multiple Sclerosis

ICD10	ICD10 Label
G35	Multiple sclerosis
G36.0	Neuromyelitis optica [Devic]
G37.0	Diffuse sclerosis of central nervous system
G37.5	Concentric sclerosis [Balo] of central nervous system

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