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.

Extavia (interferon beta-1b)

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: ☐ Extavia 0.3 mg

Start date (or date of next dose): _____
Dose Requested: _____
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).
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 try and fail two of the preferred agents including: Avonex, Glatopa, Tecfidera, or Rebif. Failure or inadequate response is defined below.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?
☐ RRMS ☐ SPMS ☐ PRMS
☐ *Other – the patient's condition is:* _____

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

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2018
Last reviewed 05/2019

D. What other treatments has the patient tried?

- ☐ Avonex **Duration**:_____ ☐ **Discontinued,** *reason*:_____
- ☐ Rebif **Duration**:_____ ☐ **Discontinued,** *reason*:_____
- ☐ Tecfidera **Duration**:_____ ☐ **Discontinued,** *reason*:_____
- ☐ Copaxone **Duration**:_____ ☐ **Discontinued,** *reason*:_____
- ☐ Glatopa **Duration**:_____ ☐ **Discontinued,** *reason*:_____
- ☐ Other, please list: _____

E. Inadequate response due to (2 of the 3 must be met):

☐ Increase in frequency (at least one clinical relapses within the past 12 months), severity and/or sequelae of relapses

☐ Changes in MRI: continues to have CNS lesion progression as measured by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions and/or T1 hypointense lesions)

☐ Increase in disability progression: Sustained worsening of EDSS score, routine neurological observation, mobility, or ability to perform activities of daily living

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