Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Multiple Sclerosis Nonpreferred Modestly Effective DMTs Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Nonpreferred Modestly Effective DMTs.** This PA form is for **Avonex (interferon beta-1A), Tecfidera (dimethyl fumarate), Rebif (interferon beta-1A), Aubagio (teriflunomide), Plegridy (peginterferon beta-1A), Vumerity (diroximel).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a neurologist ? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Patient has diagnosis of relapsing form of multiple sclerosis (including non-progressive relapsing, progressive relapsing, relapsing remitting)
   □ No □ Yes

2. **AND** patient has tried and failed a ≥3 months adequate trial, or has documented allergy or intolerance to, or is not a candidate for all the following medications:
   □ No □ Yes (check below)

   ☐ Glatiramer acetate, **AND**

   ☐ Interferon-beta 1b (Betaseron) **AND**

   ☐ Dimethyl fumarate (generic Tecfidera), **AND**

   ☐ (If ordering Aubagio) documented allergy to, or is not a candidate for teriflunomide (generic Aubagio)

3. **AND** patient does not previously or currently have high risk features for early progression to non-relapsing progressive MS. <u>High risk features defined as meeting at least 1 of the following criteria</u>:
   a. Incomplete recovery defined as an attack that lasts ≥ 30 days and has significant functional limitations with the exception of ongoing sensory symptom
   b. Relapse w sphincter dysfunction, including urinary urgency or hesitancy
   c. Motor relapse
   d. Cerebellar relapse
   e. 3 or more relapses in the first 2 years after diagnosis
   f. After at least 6 months of therapy, a relapse in the next 6 months
   g. Annualized relapse rate of ≥1
   h. After 1yr of therapy, ≥ 3 new or enlarging T2, gadolinium-enhancing lesions, or diffusion-weighted imaging lesions
   i. ≥ 1 cord lesion on imaging
   □ No □ Yes

4. **AND** patient has CBC, TSH (for interferon therapy only), LFTs (for Interferon and Aubagio) checked within the last 6 months,
   □ No □ Yes

5. **AND** patient is NOT using in addition to another DMT
   □ No □ Yes

6. **AND** patient is not pregnant and will not be pregnant soon
   □ No □ Yes

<u>Additional criteria for Aubagio only:</u>

7. Patient is a female and between 12-50 years old with a negative pregnancy test AND on highly effective contraception (highly effective contraception = oral birth control, medroxyprogesterone, IUD, implant, surgical intervention, same sex partner, partner with vasectomy)
   □ No □ Yes

8. **AND** patient does not have a documented history of neuropathy, diabetes (type 1 or 2), or other medical condition that would suggest patient is at an increased risk of developing neuropathy
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Patient has completed the following laboratory monitoring within the last 6 months

   a. Complete blood count with differential
   □ No □ Yes

   b. Liver function
   □ No □ Yes

2. **AND** patient is NOT using in addition to another disease-modifying therapy and is not pregnant**,**
   □ No □ Yes

3. **AND** patients using teriflunomide continue to meet initial review criteria
   □ No □ Yes

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**