Kaiser Permanente Health Plan of Mid-Atlantic States, Inc. **Vumerity (Diroximel Fumarate) Prior Authorization (PA)** **Pharmacy Benefits Prior Authorization Help Desk** **Length of Authorization: 12 months**

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Vumerity (Diroximel Fumarate).** Please complete and 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 this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Provider Information

Provider Name: ______________________________ Specialty: ____________________ Provider NPI: _________________

Provider Address: ____

Provider Phone #: _________________________Provider Fax #: __________________________

Please check the boxes that apply:

□ Initial Request □ Continuation of Therapy Request

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 there any reason the member cannot be changed to a preferred drug? (e.g. Avonex, Rebif, Betaseron, Copaxone 20 mg) Acceptable reasons include: **AND**
   - Allergy to preferred drug.
   - Contraindication to or drug-to-drug interaction with preferred drug.
   - History of unacceptable/toxic side effects to preferred drug.
   - Member's condition is clinically stable; changing to a preferred drug might cause deterioration of the member's condition.

   □ No □ Yes

2. Has there been a therapeutic failure of at least two preferred drugs within the same class as appropriate for diagnosis- did the patient try and fail at least one preferred injectable and Gilenya?

   □ No □ Yes

3. Is the member using for Vumerity's approved indication - treatment of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and/or active secondary progressive disease?

   □ No □ Yes

6 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

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

Provider Signature:	**Date:**

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