Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Nonpreferred Highly 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 Highly Effective DMTs .** This PA form includes **Gilenya (fingolimod), Mayzent (siponimod), and Mavenclad (cladribine).**
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. Member has a diagnosis of relapsing form of multiple sclerosis (including non-progressive relapsing, progressive relapsing, relapsing remitting)
   □ No □ Yes

2. **AND** member has failed an adequate trial (≥3 months) of, or has a documented allergy or intolerance to, or is not a candidate for:
   a. Fingolimod (generic Gilenya)
   b. AND Truxima (rituximab-abbs) or Tysabri (natalizumab)
   □ No □ Yes

3. **AND** member is NOT using requested drug therapy in addition to another DMT
   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. Member is NOT using requested drug therapy in addition to another DMT
   □ No □ Yes

2. **A**ND member is experiencing positive clinical response
   □ No □ Yes

3. **AND** for Gilenya and Mayzent only: member has been seen by a Dermatologist AND Ophthalmologist in the past 12 months
   □ 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:**

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