



**MULTIPLE SCLEROSIS Oral Medication
Prior Authorization and Patient Enrollment Form**

MSORAL
FORM# 29
C: 5.15

Complete form in its entirety and fax to number listed below

PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth		Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID#
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian	Day Telephone	Night Telephone	
Emergency Contact	Relationship	Telephone	

PRESCRIBER'S INFORMATION

Prescriber's Name	NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name
Street Address		City
State	County	Zip Code
Contact Person at Office	Prescriber Specialty	

**Please Fax Completed for to:
Fax Number 800-218-3221
Phone Number 866-843-3604**



**Department of Vermont Health Access
MULTIPLE SCLEROSIS Oral Medication
PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis:

Multiple Sclerosis

Complete for Aubagio (teriflunomide):

Patient does not have any of the following contraindications to teriflunomide

- Severe hepatic impairment
- Current treatment with leflunomide (Arava®)
- Patient who are pregnant or women of childbearing potential not using reliable contraception

Complete for Gilenya (fingolimod)

Initial Request (please complete remainder of section)

Patient has tolerated first dose under observation for a minimum of 6 hours with hourly pulse and blood pressure measurement and pre and post electrocardiogram

Date of observed first dose ____/____/____

Subsequent Request (PA Renewal)

Prescriber Additional Comments:

PRESCRIPTION

Aubagio 7mg tablet or Aubagio 14mg tablet Dispense Quantity 28

Sig: Take one tablet once daily Refill X: _____

Gilenya 0.5 mg capsules Dispense Quantity 28

Sig: Take one capsule once daily Refill X: _____

Tecfidera Capsules

Month 1- Titration Starter Pack

Sig: 120mg PO BID x 7 days #14 capsules

240mg PO BID x 23 days #46 capsules

No refills

Maintenance Rx

Sig: 240mg PO BID x 30 days Dispense Quantity: 60 refill X: _____

Prescriber's Signature: _____ **Date:** _____