VERMONT
Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Multiple Sclerosis ~

Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: _____
Physician NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____Sex: _____
Patient's Phone: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:

- HCPCS J-code or other code: _____
- Administering Provider/Facility: Name_____NPI#_____Medicaid ID#_____

Patient Diagnosis:

☐ Clinically Isolated Syndrome (CIS)

☐ Primary Progressive MS (PPMS)

☐ Relapsing-Remitting MS (RRMS)

☐ Secondary Progressive MS (SPMS)

Product Name:
Preferred After Clinical Criteria Are Met:

☐ Kesimpta® (ofatumumab) 20mg/0.4mL Auto-Injector

☐ Tysabri® (Natalizumab) IV (300mg/15mL)

Non-preferred:

☐ Ampyra® (dalfampridine ER) tablets

☐ Aubagio® (terflunamide) tablet

☐ Bafiertam® (monomethyl fumarate) capsules

☐ Briumvi™ (ublituximab-xiiy)

☐ Copaxone® (Glatiramer) 40 mg/ml Prefilled Syringe (12 per carton)

☐ Extavia® (Interferon beta-1b) 0.3 mg Prefilled Syringe (15 per carton)

☐ Gilenya® (fingolimod) capsule

☐ Glatiramer Acetate 20mg/ml Prefilled Syringe (30 per carton)

☐ Glatiramer Acetate 40 mg/ml Prefilled Syringe (12 per carton)

☐ Glatopa® (Glatiramer) 20mg/ml Prefilled Syringe (30 per carton)

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☐ Glatopa® (Glatiramer) 40 mg/ml Prefilled Syringe (12 per carton)

☐ Lemtrada® (alemtuzumab) IV (12mg/1.2mL)

☐ Mavenclad® (cladribine) tablets

☐ Mayzent® (siponimod) tablets

☐ Ocrevus® (ocrelizumab) IV (300mg/10mL)

☐ Plegridy® (Peginterferon beta-1a) Starter Pack PEN (63 mcg/0.5ml x 1 dose and 94 mcg/ml x 1dose (Therapy initiation ONLY- NO refills)

☐ Plegridy® (Peginterferon beta-1a) Prefilled PEN 125 mcg/0.5ml (2 per carton)

☐ Plegridy® (Peginterferon beta-1a) Starter Pack SYRINGE (63 mcg/0.5ml x 1 dose and 94 mcg/ml x 1dose (Therapy initiation ONLY- NO refills)

☐ Plegridy® (Peginterferon beta-1a) Prefilled SYRINGE 125 mcg/0.5ml (2 per carton)

☐ Ponvory™ (ponesimod) tablets

☐ Tascenso ODT® (fingolimod)

☐ Tecfidera® (Dimethyl fumarate) Capsules

☐ Vumerity® (diroximel fumarate) capsules

☐ Zeposia® (ozanimod) capsules

Quantity: _____Refills: _____Dose/Route/Frequency Instructions (Sig): _____

List previous medications/therapies tried and failed for this condition:

Therapy (and dates)	**Reason for discontinuation**
_____	_____
_____	_____
_____	_____

Prescriber Additional Comments: _____

_____

_____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and/or recoupment.

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

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