



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

~Multiple Sclerosis ~

Prior Authorization Request Form

In order for beneficiaries 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# _____

Please check box if this drug is being provided under the DVHA's 340B Drug program and requires the TB modifier

Patient Diagnosis:

- Clinically Isolated Syndrome (CIS)
- Primary Progressive MS (PPMS)
- Relapsing-Remitting MS (RRMS)
- Secondary Progressive MS (SPMS)

Product Name:

- Ampyra® (dalfampridine ER) tablets
- Copaxone® (Glatiramer) 40 mg/ml Prefilled Syringe (12 per carton)
- Extavia® (Interferon beta-1b) 0.3 mg Prefilled Syringe (15 per carton)
- 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)
- 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)





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

- 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)
- Tecfidera® (Dimethyl fumarate) Capsules
- Tysabri® (Natalizumab) IV (300mg/15mL)

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:** _____

