South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Multiple Sclerosis Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the medication being requested:

❑ Ampyra	❑ Briumvi	❑ Gilenya	❑ Mavenclad	❑ Rebif
❑ Aubagio	❑ Copaxone	❑ Glatiramer	❑ Mayzent	❑ Tascenso ODT
❑ Avonex	❑ Dalfampridine ER	❑ Glatopa	❑ Plegridy	❑ Tecfidera
❑ Bafiertam	❑ Extavia	❑ Kesimpta	❑ Ponvory	❑ Vumerity
❑ Betaseron				❑ Zeposia

Select the diagnosis below:

❑ Multiple sclerosis _____

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's specialty:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:

- ❑ Neurologist
- ❑ Physiatrist [Ampyra (dalfampridine ER) only]

For Ampyra (dalfampridine ER), also answer the following:

Does the patient have a history of seizures? ❑ **Yes** ❑ **No**

For Aubagio, Avonex, Bafiertam, Betaseron, Briumvi, Copaxone, Extavia, Gilenya, Glatiramer, Glatopa, Kesimpta, Lemtrada, Mayzent, Plegridy, Ponvory, Rebif, Tecfidera, or Vumerity, also answer the following:

Does the patient have a relapsing form of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease? ❑ **Yes** ❑ **No**

For mitoxantrone, also answer the following:

Select the form of multiple sclerosis that applies to the patient:

- ❑ Progressive relapsing multiple sclerosis
- ❑ Secondary progressive multiple sclerosis
- ❑ Worsening relapsing-remitting multiple sclerosis

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For Mavenclad, also answer the following:

Does the patient have a relapsing form of multiple sclerosis, including relapsing-remitting disease or active secondary progressive disease? ❑ **Yes** ❑ **No**

Has the patient already received the FDA-recommended lifetime limit of 2 treatment courses (or 4 treatment cycles total) of cladribine? ❑ **Yes** ❑ **No**

Select the disease-modifying therapies for multiple sclerosis the patient has failed after a trial of at least 4 weeks, has a contraindication to, or intolerance to:

- ❑ Aubagio (teriflunomide)
- ❑ Avonex (interferon beta-1a)
- ❑ Bafiertam (monomethyl fumarate)
- ❑ Betaseron (interferon beta-1b)
- ❑ Briumvi (ublituximab-xiiy)
- ❑ Copaxone/Glatopa (glatiramer acetate)
- ❑ Extavia (interferon beta-1b)
- ❑ Gilenya (fingolimod)
- ❑ Kesimpta (ofatumumab)
- ❑ Lemtrada (alemtuzumab)
- ❑ Mayzent (siponimod)
- ❑ Ocrevus (ocrelizumab)
- ❑ Plegridy (peginterferon beta-1a)
- ❑ Rebif (interferon beta-1a)
- ❑ Tecfidera (dimethyl fumarate)
- ❑ Tysabri (natalizumab)
- ❑ Vumerity (diroximel)
- ❑ Zeposia (ozanimod)

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.