UPMC Health Plan

GILENYA

Prior Authorization Form
If this is an urgent request, please call UPMC Health Plan Pharmacy Services.
Otherwise, please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES **PHONE: 1-800-396-4139** **FAX: 412-454-7722**

PLEASE TYPE OR PRINT NEATLY
Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:**		
Provider First Name:	**Provider Last Name:**		
Provider Phone:	**Provider Fax:**	**Provider NPI #:**	
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.

❑ **New medication** ❑ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, did member show improvement while on therapy?**	❑**Yes** ❑**No**
Diagnosis:	**Date of Diagnosis:**		

MEDICAL HISTORY

Does the member have relapsing form of Multiple Sclerosis? ☐ **Yes** ☐ **No**

Please indicate past medication(s) tried and failed:

Medication name	Start date	End date	Strength	Frequency	Reason for failure or discontinuation
☐ **AVONEX****					
☐ **COPAXONE****					
☐ **Betaseron**					
☐ **Extavia**					
☐ **Rebif**					
☐ **Tecfidera**					

Will the member be observed for 6 hours for signs and symptoms of bradycardia? ☐ **Yes** ☐ **No**

Did the member have a recent (within the past 6 months) complete blood count (CBC)? ☐ **Yes** ☐ **No**
If yes, please indicate date:

Did the member have a recent (with in the past 6 months) transaminase and bilirubin level? ☐ **Yes** ☐ **No**
If yes, please indicate date:

Does the member have evidence of active infection? ☐ **Yes** ☐ **No**

Was the member vaccinated against varicella zoster virus (VZV)? ☐ **Yes** ☐ **No**
If yes, please provide chart documentation of VZV vaccination, including date.

Has the member demonstrated immunity to VZV by VZV antibody serology? ☐ **Yes** ☐ **No**
If yes, please provide chart documentation of VZV antibody serology.

Please be sure to complete and include the 2nd page of this form.

****AVONEX and COPAXONE are the preferred products for UPMC Health Plan.**

GILENYA

Page 2

Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include this page with the 1st page of this form

Is the member on concomitant therapy with antineoplastic, immunosuppressive therapy, or immune modulating therapies? ☐ Yes ☐ No

If yes, please complete below:

Medication Name	Dose/Strength	Frequency

Did the member have a baseline ophthalmologic evaluation of the macula? ☐ Yes ☐ No

If yes, please indicate date:

Did the member have a baseline spirometric evaluation of respiratory function and evaluation of diffusion lung capacity for carbon monoxide? ☐ Yes ☐ No

If yes, please indicate date:

Did the member have a recent (within 1 month) electrocardiogram (ECG)? ☐ Yes ☐ No

If yes, please indicate date:

Has the member experienced any of the following in the past 6 months:

- ☐ Myocardial infarction
- ☐ Unstable angina
- ☐ Stroke
- ☐ Transient ischemic attack
- ☐ Decompensated heart failure requiring hospitalization
- ☐ Class III or IV heart failure

Does the member have Mobitz Type II second- or third-degree atrioventricular (AV) block or sick sinus syndrome? ☐ Yes ☐ No

If yes, does the member have a functioning pacemaker? ☐ Yes ☐ No

Please provide the member's baseline QTc interval:

Is the member on concomitant therapy with any Class I or Class III antiarrhythmic medications? ☐ Yes ☐ No

If yes, please complete below:

Medication Name	Dose/Strength	Frequency

Is this request for a reauthorization? ☐ Yes ☐ No

If yes, please include the following documentation:

- ☐ Documentation showing member's disease has stabilized
- ☐ Documentation of no active infection
- ☐ Documentation of 3-month follow-up ophthalmologic evaluation within 3 to 4 months of starting therapy, including date.
- ☐ Documentation that the member is **NOT** on concomitant therapy with antineoplastic, immunosuppressive, or immune modulating therapies.
- ☐ Documentation that the member CBC and transaminase/bilirubin levels are being monitored consistently.

Please provide any additional information which should be considered in the space below: