



# PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

## Zinbryta (daclizumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member/Subscriber Number:	<b>Supervising Physician:</b>
Date of Birth:	Fax: Phone:
Group Number:	Office Contact:
Address:	NPI: State Lic ID:
City, State ZIP:	Address:
Primary Phone:	City, State ZIP:
	Specialty/facility name (if applicable):

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. What is the patient's diagnosis? <input type="checkbox"/> Relapsing form of multiple sclerosis <input type="checkbox"/> Other (Please Specify)
Q2. Please provide the ICD code from the diagnosis provided.
Q3. Specify the prescriber's specialty. <input type="checkbox"/> Neurologist <input type="checkbox"/> Other (please specify)
Q4. Is the patient $\geq 18$ years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Does the patient have a contraindication to or failure of any of the following disease-modifying therapies? (Please select all that apply) <input type="checkbox"/> Aubagio <input type="checkbox"/> Avonex <input type="checkbox"/> Copaxone or Glatopa <input type="checkbox"/> Extavia <input type="checkbox"/> Gilenya



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Zinbryta (daclizumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

<b>Patient Name:</b>	<b>Prescriber Name:</b> <b>Supervising Physician:</b>
<input type="checkbox"/> Plegridy <input type="checkbox"/> Tecfidera <input type="checkbox"/> Tysabri <input type="checkbox"/> None of the above	
Q6. Have all other multiple sclerosis therapies been discontinued, including IVIG? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Additional Comments	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document