# PRIOR AUTHORIZATION REQUEST FORM

**EOC ID:**

# Aubagio

**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.**

| **Patient Name:** | **Prescriber Name:**<br>**Supervising Physician:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Group Number: | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | 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. Is the prescriber a Neurologist?<br>£ Yes £ No |
| Q2. Does the patient have a diagnosis of a relapsing form of multiple sclerosis?<br>£ Yes £ No |
| Q3. Please provide ICD code(s) for diagnosis. |
| Q4. Is the patient ≥18 years of age?<br>£ Yes £ No |
| Q5. Is the patient pregnant?<br>£ Yes £ No |
| Q6. Does the patient have severe hepatic impairment?<br>£ Yes £ No |
| Q7. Will the patient be taking Aubagio in COMBINATION with other immunomodulatory agents (Avonex, Copaxone, Extavia, Betaseron, Rebif, Tysabri, Gilenya, Tecfidera or leflunomide)?<br>£ Yes £ No |
| Q8. Has the patient been on the requested product in the past 180 days? |

# PRIOR AUTHORIZATION REQUEST FORM

**EOC ID:**

# Aubagio

**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.**

| | |
|---|---|
| **Patient Name:** | **Prescriber Name:**<br>**Supervising Physician:** |

£ Yes £ No

Q9. Has the patient failed, experienced a clinically significant adverse event, or does the patient have a contraindication to Gilenya or Tecfidera?

£ Yes £ No

Q10. 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.