Multiple Sclerosis Medication Precertification Request

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: ☐ Start of treatment ☐ Continuation of therapy, date of last treatment: ______________ **Today's date:** ______________ **Date needed:** ______________

Ship to: ☐ Doctor's office ☐ Patient ☐ Other: ______________ Phone: ______________
Dispensing Provider: ☐ Aetna Specialty Pharmacy® or ☐ Other: ______________
Phone: ______________ Fax: ______________ TIN: ______________ PIN: ______________

Precertification Requested By: ______________ Phone: ______________ Fax: ______________

A. PATIENT INFORMATION

First Name: | Last Name:
Address: | City: | State: | ZIP:
Home Phone: | Work Phone: | Cell Phone:
DOB: | Allergies: | Email:
Patient Current Weight: ________ lbs or ________ kgs Patient Height: ________ inches or ________ cms

B. INSURANCE INFORMATION

Aetna Member ID #: ______________
Group #: ______________
Insured: ______________

Does patient have other coverage? ☐ Yes ☐ No
If Yes, provide ID#: ______________ Carrier Name: ______________
Insured: ______________

Medicare: ☐ Yes ☐ No If Yes, provide ID #:
Medicaid: ☐ Yes ☐ No If Yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name: | Last Name: | *(Circle one):* M.D. D.O. N.P. P.A.
Address: | City: | State: | ZIP:
Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN:
Provider Email: | Office Contact Name: | Phone:
Specialty *(Check one)*: ☐ Neurologist ☐ Primary Care ☐ **Other**: ______________

D. DIAGNOSIS INFORMATION

☐ Primary ICD-9: (340) Multiple Sclerosis ☐ Secondary ICD-9: ________ ☐ Other ICD-9 Code: ________

E. CLINICAL INFORMATION

Please indicate which drug you are requesting prior authorization*: (P* is preferred, *NP* is non-preferred)

☐ **Avonex® *(P)*** ☐ **Betaseron® *(NP)*** ☐ **Copaxone® *(P)*** ☐ **Extavia® *(NP)*** ☐ **Gilenya® *(NP)*** ☐ **Rebif® *(P)*** ☐ **Tysabri® *(NP)***

For all drugs please complete the following questions:

☐ Yes ☐ No Does the patient have a documented diagnosis of multiple sclerosis?
☐ Yes ☐ No Has the patient experienced signs and symptoms of Clinically Isolated Syndrome suggestive of MS that has been confirmed with magnetic resonance imaging (MRI)?
☐ Yes ☐ No Does the patient have a contraindication intolerance or allergy to Avonex, Copaxone or Rebif?
☐ Yes ☐ No Does the patient have a documented failure of an adequate trial of at least one month of Avonex, Copaxone or Rebif?
If Yes, please indicate which drug(s): ☐ Avonex ☐ Copaxone ☐ Rebif

If requesting Gilenya in addition please complete the following:

☐ Yes ☐ No Will Gilenya be used as monotherapy for treatment of the patient's multiple sclerosis?
☐ Yes ☐ No Does the patient have a documented recent (within 6 months) complete blood count (CBC)?
☐ Yes ☐ No Does the patient have a documented recent (within 6 months) liver transaminase and bilirubin?
☐ Yes ☐ No Does the patient have a documented recent (within 6 months) EKG if member is using a antiarrhythmic (such as beta-blockers, calcium channel blockers,1a and Class III antiarrhythmics) or with history of 2nd degree or higher AV block, sick sinus syndrome, prolonged QT interval, ischemic cardiac disease, congestive heart failure, heart rate below 55 bpm, or irregular heart beat?
☐ Yes ☐ No Does the patient have a documented baseline ophthalmologic examination?
☐ Yes ☐ No Does the patient have a documented history of chicken pox or administration of the varicella zoster vaccine (VZV). If history of chicken pox or administration of VZV is unknown then titers should be drawn and if low VZV should be considered?
☐ Yes ☐ No If female, does the patient have a documented negative pregnancy test?

If requesting Tysabri in addition please complete the following:

☐ Yes ☐ No Will Tysabri be used as monotherapy for treatment of the patient's multiple sclerosis?

F. PRESCRIPTION – Prescriptions will be forwarded to Aetna Specialty Pharmacy (1-866-782-2779) if it is the selected dispensing provider

☐ **AVONEX 30mcg** ☐ **PFS** *OR* ☐ **Vials**
4/box # of boxes ______ # of Refills ______
☐ ***Supplies***: Needles 25g 1 inch
☐ ***Directions:*** 30mcg IM weekly ☐ Other: ______________

☐ **BETASERON 0.3mg** 14/box *OR* ☐ **EXTAVIA 0.3mg** 15/box
# of boxes ______ # of Refills ______ # of boxes ______ # of Refills ______
☐ ***Directions (Initial Titration):***
0.0625mg (0.25ml) SQ every other day for Weeks 1 & 2,
0.125mg (0.5ml) SQ every other day for Weeks 3 & 4,
0.1875mg (0.75ml) SQ every other day for Weeks 5 & 6,
0.25mg (1ml) SQ every other day Week 7+
☐ ***Directions:*** 0.25mg (1ml) SQ every other day
☐ Other: ______________

☐ **GILENYA 0.5mg capsule**
28/dose pack # of dose packs ______ # of Refills ______
☐ ***Directions:*** 1 capsule PO daily ☐ Other: ______________

☐ **COPAXONE 20 mg PFS**
30/box # of boxes ______ # of Refills ______
☐ ***Directions:*** 20 mg SQ daily ☐ Other:

☐ **REBIF Titration Kit** #1box (12PFS) **+** No Refills
Directions (Initial Titration):
8.8 mcg SQ 3 times a week for Weeks 1 & 2,
22 mcg SQ 3 times a week for Weeks 3 & 4

☐ **REBIF** ☐ **22 mcg** *OR* ☐ **44 mcg**
12/box # of boxes ______ # of boxes ______
☐ ***Directions:*** Inject three times a week ☐ Other:

☐ **OTHER DRUG:** ______________ **Strength**: ______________
Directions: ______________
# of Refills ______ Quantity: ______

☐ **TYSABRI - Available only under a special restricted distribution program. Please contact the TOUCH Prescribing Program at www.tysabri.com or 1-800-456-2255.**

If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.
*** If the prescriber is providing the drug, the provider must verify benefits.**

Prescriber's Signature: ______________ **Date:** ____/____/____
(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)

Interchange is mandated unless practitioner writes the words "Brand Medically Necessary" in this space. ______________