



Gilenya® (fingolimod)
Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification

Phone: 1-855-240-0535

FAX: 1-877-269-9916

For Medicare Advantage Part B:

FAX: 1-844-268-7263

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy: Date of last treatment ____ / ____ / ____

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:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Neurologist <input type="checkbox"/> Primary Care <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:	Dispensing Provider/Pharmacy: Patient Selected choice
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy
<input type="checkbox"/> Outpatient Infusion Center Phone: _____	<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order
Center Name: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Home Infusion Center Phone: _____	Name: _____
Agency Name: _____	Phone: _____ Fax: _____
<input type="checkbox"/> Administration code(s) (CPT): _____	Address: _____
Address: _____	TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Gilenya: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests:
Please indicate the type of multiple sclerosis the patient has been diagnosed with:
 Relapsing -remitting MS Secondary- progressive MS Primary- progressive MS Progressive- relapsing MS
 Yes No Has the patient discontinued other medications used for treating MS (not including Ampyra)?
 Yes No Will the patient have an ECG prior to the first dose and at the end of the observation period?

For Initiation Requests:
 Yes No Does the patient have a documented recent (within 6 months) complete blood count (CBC)?
→ Please indicate the date of the CBC testing: Date: ____ / ____ / ____
 Yes No Does the patient have a documented recent (within 6 months) liver transaminase and bilirubin?
→ Please indicate the results and date of the lab work: ALT: _____ IU/mL Date: ____ / ____ / ____
AST: _____ IU/mL Date: ____ / ____ / ____
Bilirubin: _____ mg/dL Date: ____ / ____ / ____

Yes No Has the patient had a recent (within the last 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure?
 Yes No Does the patient have history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome?
 Yes No Does the patient have a pacemaker?
 Yes No Does the patient have a baseline QTc interval ≥500 ms (as measured on most recent ECG)?
 Yes No Is the patient on any Class Ia or Class III anti-arrhythmic drugs?
 Yes No Does the patient have a documented baseline ophthalmologic examination? **If yes**, date of the eye exam: Date: ____ / ____ / ____
 Yes No Does the patient have a documented history of chicken pox or administration of the varicella zoster vaccine (VZV)?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

For Restart Requests:

Please enter the date treatment was stopped: Date: ____ / ____ / ____

Yes No Will the patient have an ECG prior to first re-initiated dose and at the end of the observation period?

For Continuation Requests:

Yes No Is this continuation request a result of the patient receiving samples of Gilenya? (Sampling of Gilenya does not guarantee coverage under the provisions of the pharmacy benefit)

Yes No Is there clinical documentation supporting disease stability?

Yes No Is there clinical documentation supporting disease improvement?

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.