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United Healthcare Community Plan

**COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

**Service Authorization (SA) Form**

**MULTIPLE SCLEROSIS**

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

## MEMBER INFORMATION

**Last Name:** _____

**First Name:** _____

**Medicaid ID Number:** _____

**Date of Birth:** _____

**Weight in Kilograms**: _____

## PRESCRIBER INFORMATION

**Last Name:** _____

**First Name:** _____

**NPI Number:** _____

**Phone Number:** _____

**Fax Number:** _____

## DRUG INFORMATION

**Drug Name/Form:** _____

**Strength:** _____

**Dosing Frequency:** _____

**Length of Therapy:** _____

**Quantity per Day:** _____

*(Form continued on next page.)*

**Member's Last Name:** **Member's First Name:**

## DIAGNOSIS AND MEDICAL INFORMATION

1. Is the member at least 18 years of age?

   ☐ Yes ☐ No

2. Has the member had a baseline magnetic resonance imaging (MRI) before initiating the first treatment course (within 3 months prior to start of therapy)?

   ☐ Yes ☐ No

3. Indicate all that apply:

   ☐ Relapsing-remitting disease (RRMS) ☐ Secondary progressive disease (SPMS) with relapses

   ☐ Clinically isolated syndrome (CIS) ☐ Member has had ≥ 1 relapse within the previous two years

   ☐ Member has new and unequivocally enlarging T2 contrast enhancing lesions as evidenced by MRI and has had ≥ 1 relapse in the previous 12 months

   ☐ Other: _____

4. Has the member had a treatment failure or contraindication to other agents used to treat multiple sclerosis (MS)? List previous medications (include drug name/dose):

   ☐ Yes ☐ No

   Previous Medication(s): _____

5. Will Mavenclad®, Mayzent®, Ponvory™, Zeposia® be used as single-agent therapy?

   ☐ Yes ☐ No

6. Has the member been tested for antibodies to the varicella zoster virus (VZV) or received immunization for VZV four weeks prior to beginning therapy?

   ☐ Yes ☐ No

7. Has the member been screened for the presence of tuberculosis according to local guidelines?

   ☐ Yes ☐ No

8. Has the member been evaluated and screened for the presence of hepatitis B and hepatitis C virus (HBV/HCV) prior to initiating treatment?

   ☐ Yes ☐ No

*(Form continued on next page.)*

**Member's Last Name:** **Member's First Name:**

9. **Mavenclad® Specific**

   a. Is the lymphocyte count ≥ 800 cells/mL prior to start of therapy?

   ☐ Yes ☐ No

   b. Please attest that members of childbearing age are not pregnant **and** that members of reproductive potential must use effective contraception during treatment with therapy and for at least six months after the last dose.

   ☐ Yes ☐ No

   c. Does the member have human immunodeficiency virus (HIV) infection?

   ☐ Yes ☐ No

10. **Mayzent® Specific**

   a. Has the member been tested for CYP2C9 variant status to determine genotyping (required for dosing)?

   ☐ Yes ☐ No

11. **Mayzent®, Ponvory™ or Zeposia® Specific**

   a. Please attest that members of childbearing age are not pregnant and that members of reproductive potential must use effective contraception during treatment.

   ☐ Yes ☐ No

   b. Has the member obtained a baseline electrocardiogram (ECG)?

   ☐ Yes ☐ No

   c. Has the member had a baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment?

   ☐ Yes ☐ No

12. Before using **Mayzent®, Ponvory™ or Zeposia®**, can you attest that the member does **not** have any of the following:

   - Recent myocardial infarction
   - Unstable angina
   - Stroke
   - Transient ischemic attack
   - Decompensated heart failure with hospitalization
   - Class III/IV heart failure within the previous 6 months
   - Prolonged QTc interval at baseline (> 500 msec)
   - CYP2C9*3/*3 genotype (**Mayzent® only)**
   - History of Mobitz Type II second or third-degree atrioventricular block or sick sinus syndrome (unless treated with a functioning pacemaker)

   ☐ Yes ☐ No

*(Form continued on next page.)*

**Member's Last Name:** **Member's First Name:**

13. Can you confirm that **Mayzent®** will **not** be used in combination with the following?:

- Moderate or strong CYP3A4 inducers (e.g., modafinil, efavirenz) in members with a CYP2C9*1/*3 and CYP2C9*2/*3 genotypes; **OR**
- Drug regimens that contain CYP2C9/CY3A4 dual inhibitors (e.g., fluconazole); **OR**
- Moderate CYP2C9 inhibitor plus a moderate-to-strong CYP3A4 inhibitor; **OR**
- Other antineoplastic, immunosuppressive or immunomodulating drugs.

☐ Yes ☐ No

14. Can you confirm **Zeposia®** will **not** be used in combination with the following?:

- Will **not** be initiating therapy after previous treatment with alemtuzumab; **OR**
- Monoamine oxidase inhibitor (MAOI) (e.g., selegiline, phenelzine, linezolid); **OR**
- Drugs known to prolong the QT-interval (e.g., fluoroquinolone or macrolide antibiotics, venlafaxine, fluoxetine, quetiapine, ziprasidone, sumatriptan, zolmitriptan); **OR**
- Strong cytochrome p450 2C8 (CYP2C8) inhibitors (e.g., gemfibrozil) or inducers (e.g., rifampin); **OR**
- BCRP inhibitors (e.g., cyclosporine, eltrombopag); **OR**
- Adrenergic or serotonergic drugs which can increase norepinephrine or serotonin (e.g., opioids, selective serotonin reuptake inhibitors [SSRIs], selective norepinephrine reuptake inhibitors [SNRIs], tricyclics, tyramine); **OR**
- Foods with large amounts of tyramine (e.g., > 150 mg), such as aged cheeses, cured meats, craft/unfiltered beers, beans); **OR**
- Other antineoplastic, immunosuppressive or immunomodulating drugs (**Note**: if there is a history of prior use of these drugs, consider possible unintended additive immunosuppressive effects); **AND**
- Patient will **not** receive live vaccines during and at least 4 weeks prior to and 12 weeks after treatment; **AND**
- Patient does **not** have an active infection, including clinically important localized infections

☐ Yes ☐ No

**Prescriber Signature (Required)** **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the SA process.**
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826