

Network Health Sphingosine 1-Receptor Modulators Prior Authorization Request

Medication Request Form (MRF)

Gilenya (fingolimod)

FAX TO: (877) 501-1059

c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department

10680 Treena Street, Suite 500, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:

This form is to be used by participating providers to obtain coverage for the drugs listed above, which require prior authorization. Please complete this form and fax it to MedImpact Healthcare Systems, Inc. at (877) 501-1059. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

***** ONLY COMPLETED FORMS CAN BE PROCESSED *****

Member/Provider Information:

Member's Name:	Prescriber/Provider's Name:
Member's Network Health ID #:	Prescriber/Provider's Specialty:
Member's DOB (mm-dd-yy):	DEA #(Required): _____ NPI #: _____
Pharmacy used by Member:	Prescriber/Provider's Telephone Number/ Contact Name:
Pharmacy (Area Code) Telephone Number:	Prescriber/Provider's (Area Code) Fax Number:

MEDICATION REQUEST INFORMATION
Please check all that apply: <input type="checkbox"/> Gilenya 0.5mg by mouth once daily.

REQUIRED CLINICAL INFORMATION
Please check all that apply: <u>Diagnosis</u> <input type="checkbox"/> 340.0 Multiple Sclerosis (relapsing forms) <input type="checkbox"/> Other: _____
• Has the patient tried and failed therapy with any of the disease modifying agents listed below? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please check all appropriate therapies below: <input type="checkbox"/> Avonex When: _____ <input type="checkbox"/> Betaseron When: _____ <input type="checkbox"/> Copaxone When: _____ <input type="checkbox"/> Extavia When: _____ <input type="checkbox"/> Rebif When: _____ <input type="checkbox"/> Tysabri When: _____
If the patient has not tried any of the therapies above, please provide clinical rationale as to why one of the above disease modifying agents cannot be used in this patient. _____ _____

Request for expedited review (72 hours): By checking this box, I certify that applying the standard review time frame may seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

Prescriber's signature (STAMP NOT ACCEPTED)

Date

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Contacted:
Provider:
Pharmacy:
Patient:

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #