FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

# Gilenya® Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if **generic substitution** is acceptable<br>❑ Check if request is for **continuation of therapy** | Directions for Use: | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Multiple sclerosis (MS)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Clinical Information:**

Does the patient have a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses)? ❑ **Yes** ❑ **No**

**Quantity Limit Requests:**

What is the quantity requested per DAY? _____

**What is the reason for exceeding the plan limitations?**

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.