

Gilenya® Prior Authorization Request Form

Member 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: Zip: Medication Information (required) Medication Name: Strength: Dosage Form: © Check if generic substitution is acceptable Directions for Use: Directions for Use: Clinical Information (required) Select the diagnosis below: Other diagnosis (MS) Directions for Use: Other diagnosis (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)? Under Year (Provider Name) 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		DO NOT COPY FOR FU	<u>TURE USE. FORMS ARI</u>	E UPDATED FREQU	UENTLY AND MAY B	E BARCODED	
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Please note: This request may be denied unless all required information is received.	Please note: This rec	quest may be denied unless	s all required information	is received.			

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