

Prior Authorization
JOHNS HOPKINS HEALTH PLANS (MEDICAID) Gilenya - Priority Partners MCO This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at 1-410-424-4607 . Please contact Johns Hopkins Health Plans at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Gilenya - Priority Partners MCO.

Drug Name (select from list of drugs shown) Gilenya (fingolimod)

Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If yes, skip to question 9.]	

2. Does the patient have a diagnosis of relapsing remitting multiple sclerosis (RRMS) confirmed by MRI?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 5.]	
3. Does the patient have a diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 5.]	
4. Does the patient have a history of clinically isolated syndrome (CIS) confirmed by MRI?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Will the patient receive concurrent therapy with more than one disease-modifying multiple sclerosis (MS) therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
6. Is the patient between 10 and 17 years of age?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
7. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
8. Does the patient have a documented trial and inadequate response to injectable therapy, evidenced by frequent relapses, increasing MRI disease activity, or progressive disability?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[No further questions.]	
9. Has the patient shown an adequate response to treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
10. Will the patient receive concurrent therapy with more than one disease-modifying multiple sclerosis (MS) therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date