Prior Authorization Request Form for monomethyl fumarate (Bafiertam)

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________
Address: ______________________ Address: ______________________
______________________ ______________________
Sponsor ID # ______________________ Phone #: ______________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question		
1. What is the indication or diagnosis?	☐ Relapsing form of Multiple Sclerosis (MS) - Proceed to question **2** ☐ Other – **STOP** Coverage not approved	
2. Has the patient had at least a two-week trial of Tecfidera?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Has the patient failed therapy with Tecfidera?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has a complete blood count been drawn within six months prior to initiation of therapy, due to risk of lymphopenia?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Will the requested medication be used in combination with other disease-modifying drugs of MS?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

______________________ Prescriber Signature ______________ Date

[26 August 2020]

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monomethyl fumarate **(Bafiertam)**

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: