TRICARE Prior Authorization Request Form for
fingolimod **(Gilenya)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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:**

1. Does the patient have a documented diagnosis for a relapsing form of multiple sclerosis (MS)?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. Will Gilenya be used with a disease-modifying therapy (for example, Aubagio, Avonex, Betaseron, Copaxone, Extavia, Rebif, Tecfidera, Tysabri)?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 3
3. Does the patient have a recent history within the last 6 months of: class III or class IV heart failure, myocardial infarction, unstable angina, stroke, transient ischemic attack [TIA], or decompensated heart failure requiring hospitalization?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 4
4. Does the patient have a history or presence of Mobitz type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless they have a functioning pacemaker?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 5
5. Does the patient have a baseline QTc interval of 500 milliseconds (msec) or greater?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 6
6. Is the patient receiving treatment with a class Ia or class III antiarrhythmic drug (for example, disopyramide [Norpace], quinidine, procainamide, amiodarone, dofetilide [Tikosyn], dronedarone [Multaq], sotalol [Betapace]?	☐ 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

[04 March 2015]

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