Prior Authorization Request Form for
cladribine **(Mavenclad)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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. Is the requested medication being prescribed by or in consultation with a neurologist?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a documented diagnosis of relapsing-remitting multiple sclerosis, or active secondary progressive multiple sclerosis?	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Will Mavenclad be used in conjunction with another disease-modifying therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **4**
4. Has the patient failed another disease-modifying therapy?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have current malignancy?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **6**
6. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **7**
7. Does the patient (male or female) have reproductive potential?	☐ Yes proceed to question **8**	☐ No proceed to question **9**

Continue on next page

8. Does the patient (male or female) plan to use effective contraception during treatment and 6 months after the last dose?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have an active chronic infection (for example, hepatitis, tuberculosis, or HIV infection)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**
10. Will hematological and lymphocytic parameters be monitored before, during, and after treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

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

_____ _____

Prescriber Signature Date

[19 June 2019]

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