Prior Authorization Request Form for
siponimod **(Mayzent)**

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<br>proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Does the patient have a documented diagnosis of clinically isolated syndrome, relapsing-remitting multiple sclerosis, or active secondary progressive multiple sclerosis?** | ☐ Yes<br>proceed to question **3** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Will Mayzent be used in conjunction with another disease-modifying therapy?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>proceed to question **4** |
| **4. Has the patient failed a course of fingolimod (Gilenya)?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>proceed to question **5** |
| **5. Has all recommended Mayzent monitoring been completed and patient will be monitored throughout treatment as recommended in the label? (Monitoring includes CBC, LFT, varicella zoster virus (VZV) antibody serology, genotyping of CYP2C9, ECG, and macular edema screening.)** | ☐ Yes<br>proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Does the patient have a CYP2C9 *3/*3 genotype?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>proceed to question **7** |

*Continue on next page*

| | | |
|---|---|---|
| **7. Does the patient have CYP2C9 *1/*3 or *2/*3?** | ☐ Yes<br>proceed to question **8** | ☐ No<br>proceed to question **9** |
| **8. Will the maintenance dosing exceed 1mg daily?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>proceed to question **9** |
| **9. Does the patient have significant cardiac history, including: a recent history (within the past 6 months) of class III/IV heart failure, myocardial infarction, unstable angina, stroke, transient ischemic attack, or decompensated heart failure requiring hospitalization.** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>proceed to question **10** |
| **10. 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<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**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 _____

[23 May 2019]

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