TRICARE Prior Authorization Request Form for
Fingolimod **(Tascenso ODT)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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. Is the patient GREATER THAN or EQUAL to 10 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a documented diagnosis of a relapsing form of multiple sclerosis (MS)?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by a neurologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed or does the patient have a contraindication (for example, swallowing difficulties) to fingolimod capsule?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient concurrently using a disease-modifying therapy (such as, beta interferons [Avonex, Betaseron, Rebif, Plegridy, Extavia], glatiramer [Copaxone, Glatopa], dimethyl fumarate [Tecfidera], diroximel fumarate [Vumerity], monomethyl fumarate [Bafiertam], cladribine [Mavenclad], teriflunomide [Aubagio])?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. Is the patient of childbearing potential?	☐ Yes Proceed to question **7**	☐ No Proceed to question **8**
7. Does the patient agree to use effective contraception during treatment and for 2 months after stopping therapy?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

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8. Has the patient failed a course of another S1p receptor modulator (such as, Gilenya, Mayzent, Zeposia, Ponvory)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Does the provider acknowledge that all recommended Tascenso ODT monitoring has been completed and the patient will be monitored throughout treatment as recommended in the package insert? Monitoring includes complete blood count (CBC); liver function tests (LFT), varicella zoster virus (VZV) antibody serology, electrocardiogram (ECG), pulmonary function tests (PFTs), blood pressure, skin assessments and macular edema screening as indicated.	☐ 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

[17 May 2023]

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