Prior Authorization Request Form for
dimethyl fumarate (Tecfidera)

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. Does the patient have a documented diagnosis of a relapsing form of multiple sclerosis (MS)?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Has a CBC (complete blood count) been obtained within 6 months prior to initiation of therapy, due to risk of lymphopenia?	☐ Yes Proceed to question 3	☐ No Coverage not approved
3. Will dimethyl fumarate (Tecfidera) be used concomitantly with other disease-modifying drugs used in the treatment of MS (multiple sclerosis) (for example, Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Novantrone, Rebif, Tysabri) **?**	☐ Yes 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

[22 Jan 2014]

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