Prior Authorization Request Form for
diroximel fumarate **(Vumerity)**

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 #:

1. Does the patient have a documented diagnosis of a relapsing form of Multiple Sclerosis (MS)?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Has the patient had at least a two-week trial of Tecfidera and failed therapy?	☐ Yes Proceed to question **4**	☐ No Proceed to question **3**
3. Has the patient had at least a two-week trial of Tecfidera and continues to have GI side effects not expected to occur with Vumerity?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient had a complete blood count drawn within six months prior to initiation of therapy, due to risk of lymphopenia?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Will the requested medication be used along with other disease-modifying drugs of MS?	☐ 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

[13 May 2020]

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