2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Fingolimod hydrochloride

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Request Type:

☐ Initial - Go to 2 ☐ Continuation - Go to 5

Q2. Is the requested medication being prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q3. Is the requested medication being used concomitantly with other disease modifying multiple sclerosis agents? Note: Ampyra and Nuedexta are not disease modifying.

☐ Yes ☐ No

Q4. Does the patient have one of the following diagnoses:
A) Relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse)
B) Clinically isolated syndrome of multiple sclerosis?

☐ Yes ☐ No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Fingolimod hydrochloride

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q5. For reauthorization, is the patient experiencing disease stability or improvement while receiving the requested medication?

☐ Yes ☐ No

Q6. Additional Information:

____ _______________________________

Prescriber Signature Date

2024 Prior Authorization Request

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document