

## AllCare Plus Pharmacy, Inc. Prior Authorization Checklist (optional)

**Patient Name:** \_\_\_\_\_

**ICD-10 Code:** \_\_\_\_\_

1. Does the patient have a documented diagnosis of relapsing forms of MS?  Yes  No

2. Will the requested drug be used as monotherapy?  Yes  No

2a. If no, what other disease modifying agents will be used in combination with the requested medication?

\_\_\_\_\_

\_\_\_\_\_

3. Did the patient have an MRI scan that demonstrated features consistent with a diagnosis of MS?  Yes  No

4. Please provide your clinical rationale for prescribing the requested medication over current formulary alternatives?

\_\_\_\_\_

\_\_\_\_\_

5. Is there a recent history of a first clinical demyelinating event? (e.g., Optic Neuritis, Incomplete Transverse Myelitis or Brainstem/ Cerebellar Syndrome)

Yes  No

5a. If yes, does the patient have MRI-detected brain lesions consistent with Multiple Sclerosis?

Yes  No

6. Does the patient have a history of failure, intolerance, or contraindication to any of the following medications?

|           |                              |                             | Dates of treatment | Reason for discontinuation |
|-----------|------------------------------|-----------------------------|--------------------|----------------------------|
| Aubagio   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              | _____                      |
| Avonex    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              | _____                      |
| Betaseron | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              | _____                      |
| Copaxone  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              | _____                      |
| Extavia   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              | _____                      |
| Gilenya   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              | _____                      |
| Plegridy  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              | _____                      |
| Rebif     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              | _____                      |
| Tecfidera | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              | _____                      |
| Tysabri   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____              | _____                      |

Other: \_\_\_\_\_



**I authorize AllCare Plus Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.**

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