AllCare Plus Pharmacy, Inc.
Fax # 1 (844) 265-0265

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	☐ Yes	☐ No	_____	_____
Avonex	☐ Yes	☐ No	_____	_____
Betaseron	☐ Yes	☐ No	_____	_____
Copaxone	☐ Yes	☐ No	_____	_____
Extavia	☐ Yes	☐ No	_____	_____
Gilenya	☐ Yes	☐ No	_____	_____
Plegridy	☐ Yes	☐ No	_____	_____
Rebif	☐ Yes	☐ No	_____	_____
Tecfidera	☐ Yes	☐ No	_____	_____
Tysabri	☐ Yes	☐ No	_____	_____

Other: _____

ALLCARE PLUS PHARMACY

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