AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

MULTIPLE SCLEROSIS

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

1. Is the member at least 18 years of age?

   ☐ Yes ☐ No

2. Has the member had a baseline magnetic resonance imaging (MRI) before initiating the first treatment course (within 3 months prior to start of therapy)?

   ☐ Yes ☐ No

3. Indicate all that apply:

   ☐ Relapsing-remitting disease (RRMS)
   ☐ Secondary progressive disease (SPMS) with relapses
   ☐ Clinically isolated syndrome (CIS)
   ☐ Member has had ≥ 1 relapse within the previous two years
   ☐ Member has new and unequivocally enlarging T2 contrast enhancing lesions as evidenced by MRI and has had ≥ 1 relapse in the previous 12 months
   ☐ Other: _____

4. Has the member had a treatment failure or contraindication to other agents used to treat multiple sclerosis (MS)? List previous medications (include drug name/dose):

   ☐ Yes ☐ No

   Previous Medication(s): _____

5. Will Mavenclad®, Mayzent®, Ponvory™, Zeposia® be used as single-agent therapy?

   ☐ Yes ☐ No

6. Has the member been tested for antibodies to the varicella zoster virus (VZV) or received immunization for VZV four weeks prior to beginning therapy?

   ☐ Yes ☐ No

7. Has the member been screened for the presence of tuberculosis according to local guidelines?

   ☐ Yes ☐ No

8. Has the member been evaluated and screened for the presence of hepatitis B and hepatitis C virus (HBV/HCV) prior to initiating treatment?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

9. **Mavenclad® Specific**

   a. Is the lymphocyte count ≥ 800 cells/mL prior to start of therapy?

   ☐ Yes ☐ No

   b. Please attest that members of childbearing age are not pregnant **and** that members of reproductive potential must use effective contraception during treatment with therapy and for at least six months after the last dose.

   ☐ Yes ☐ No

   c. Does the member have human immunodeficiency virus (HIV) infection?

   ☐ Yes ☐ No

10. **Mayzent® Specific**

   a. Has the member been tested for CYP2C9 variant status to determine genotyping (required for dosing)?

   ☐ Yes ☐ No

11. **Mayzent®, Ponvory™ or Zeposia® Specific**

   a. Please attest that members of childbearing age are not pregnant and that members of reproductive potential must use effective contraception during treatment.

   ☐ Yes ☐ No

   b. Has the member obtained a baseline electrocardiogram (ECG)?

   ☐ Yes ☐ No

   c. Has the member had a baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment?

   ☐ Yes ☐ No

12. Before using **Mayzent®, Ponvory™ or Zeposia®**, can you attest that the member does **not** have any of the following:

- Recent myocardial infarction
- Unstable angina
- Stroke
- Transient ischemic attack
- Decompensated heart failure with hospitalization
- Class III/IV heart failure within the previous 6 months
- Prolonged QTc interval at baseline (> 500 msec)
- CYP2C9*3/*3 genotype (**Mayzent® only)**
- History of Mobitz Type II second or third-degree atrioventricular block or sick sinus syndrome (unless treated with a functioning pacemaker)

☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

13. Can you confirm that **Mayzent®** will **not** be used in combination with the following?:

- Moderate or strong CYP3A4 inducers (e.g., modafinil, efavirenz) in members with a CYP2C9*1/*3 and CYP2C9*2/*3 genotypes; **OR**
- Drug regimens that contain CYP2C9/CY3A4 dual inhibitors (e.g., fluconazole); **OR**
- Moderate CYP2C9 inhibitor plus a moderate-to-strong CYP3A4 inhibitor; **OR**
- Other antineoplastic, immunosuppressive or immunomodulating drugs.

☐ Yes ☐ No

14. Can you confirm **Zeposia®** will **not** be used in combination with the following?:

- Will **not** be initiating therapy after previous treatment with alemtuzumab; **OR**
- Monoamine oxidase inhibitor (MAOI) (e.g., selegiline, phenelzine, linezolid); **OR**
- Drugs known to prolong the QT-interval (e.g., fluoroquinolone or macrolide antibiotics, venlafaxine, fluoxetine, quetiapine, ziprasidone, sumatriptan, zolmitriptan); **OR**
- Strong cytochrome p450 2C8 (CYP2C8) inhibitors (e.g., gemfibrozil) or inducers (e.g., rifampin); **OR**
- BCRP inhibitors (e.g., cyclosporine, eltrombopag); **OR**
- Adrenergic or serotonergic drugs which can increase norepinephrine or serotonin (e.g., opioids, selective serotonin reuptake inhibitors [SSRIs], selective norepinephrine reuptake inhibitors [SNRIs], tricyclics, tyramine); **OR**
- Foods with large amounts of tyramine (e.g., > 150 mg), such as aged cheeses, cured meats, craft/unfiltered beers, beans); **OR**
- Other antineoplastic, immunosuppressive or immunomodulating drugs (**Note**: if there is a history of prior use of these drugs, consider possible unintended additive immunosuppressive effects); **AND**
- Patient will **not** receive live vaccines during and at least 4 weeks prior to and 12 weeks after treatment; **AND**
- Patient does **not** have an active infection, including clinically important localized infections

☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.