

US Family Health Plan Pharmacy Program

Gilenya (fingolimod) Prior Authorization Request

This form applies to the US Family Health Plan Mail Order Pharmacy and the US Family Health Plan Retail Pharmacy programs. This form must be completed and signed by the prescriber.

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> The completed form and the prescription may be faxed to 1-617-562-5296 OR The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 		<ul style="list-style-type: none"> The provider may call: 1-877-880-7007 <li style="text-align: center;">OR The completed form may be faxed to 1-617-562-5296

Prior authorization criteria and a copy of this form are available at:
http://www.usfamilyhealth.org/f-downloadable_forms.html This prior authorization has no expiration date.

Step 1 Please complete patient and physician information (Please Print)

Patient Name: _____ Address: _____ Sponsor ID: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax: _____
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Step 2 Please complete the clinical assessment:

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1. Does the patient have a documented diagnosis for a relapsing form of multiple sclerosis (MS)?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No Coverage not approved
2. Will Gilenya be used concurrently with an interferon alpha or interferon beta agent, or Copaxone?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Sign and date below

examples of interferon alpha and beta agents include Avonex, Betaseron, Extavia, Rebif, Alferon N, Infergen, Intron A, Pegasys, and PegIntron

Step 3 I certify the above is correct and accurate to the best of my knowledge. Please sign and date

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Prescriber Signature	Date
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