

Prior Authorization Request Form for Gilenya (fingolimod)



5631

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477 The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TPharmPA@express-scripts.com
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Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php. This prior authorization has no expiration date.

Step 1 Please complete patient and physician information (please print):

<p>1 Patient Name: _____</p> <p>Address: _____</p> <p>Sponsor ID #: _____</p> <p>Date of Birth: _____</p>	<p>Physician Name: _____</p> <p>Address: _____</p> <p>Phone #: _____</p> <p>Secure Fax #: _____</p>
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Step 2 Please complete the clinical assessment:

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^a, or Copaxone?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Sign and date below

^a 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 true to the best of my knowledge.

Please sign and date:

 Prescriber Signature _____
 Date