



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Multiple Sclerosis Agents**

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. The request is for renewal of a prior authorization for the Multiple Sclerosis Agent that was previously approved. If YES, go to 9.

Yes

No

Q2. For Zeposia (ozanimod) for the treatment of ulcerative colitis, see the prior authorization guideline related to Ulcerative Colitis Agents.

Yes

No

Q3. The member meets ALL of the following:

- Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration(FDA)-approved package labeling or a medically accepted indication
- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Is prescribed a dose that is consistent with the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Does not have a contraindication to the prescribed Multiple Sclerosis Agent

Q4. The MS Agent is prescribed by one of the following:

## Multiple Sclerosis Agents

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Member Name:	Prescriber Name:
--------------	------------------

For Ampyra (dalfampridine ER), a neurologist or physical medicine and rehabilitation (PM&R) specialist

For all other Multiple Sclerosis Agents, a neurologist

**Q5. For a non-preferred Multiple Sclerosis Agent, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Multiple Sclerosis Agents approved or medically accepted for the beneficiary's diagnosis.**

Yes

No

**Q6. The member meets ONE of the following:**

Has a current prescription (within the past 90 days) for the same non-preferred Multiple Sclerosis Agent (does not apply to non-preferred Multiple Sclerosis Agents when a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic is preferred)

For a non-preferred Multiple Sclerosis Agent with a dosing interval exceeding 90 days (e.g., Lemtrada, Mavenclad), is receiving treatment with the same non-preferred Multiple Sclerosis Agent and will continue therapy at a dosing interval supported by FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

**Q7. For Ampyra (dalfampridine ER), has motor dysfunction on a continuous basis that impairs the ability to complete instrumental activities of daily living or activities of daily living.**

Yes

No

**Q8. For Mavenclad (cladribine), has documentation of a recent lymphocyte count within recommended limits according to FDA-approved package labeling before initiating the first treatment course.**

Yes

No

**Q9. The member meets BOTH of the following:**

Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Does not have a contraindication to the prescribed Multiple Sclerosis Agent

## Multiple Sclerosis Agents

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Member Name:	Prescriber Name:
--------------	------------------

Q10. Is prescribed the Multiple Sclerosis Agent by one of the following:

For Ampyra (dalfampridine ER), a neurologist or PM&R specialist

For all other Multiple Sclerosis Agents, a neurologist

Q11. For Ampyra (dalfampridine ER), has a documented improvement in motor function.

Yes

No

Q12. For all other Multiple Sclerosis Agents, ONE of the following:

For a Multiple Sclerosis Agent prescribed for a diagnosis of a relapsing form of multiple sclerosis, has documented improvement or stabilization of the multiple sclerosis disease course

For a Multiple Sclerosis Agent prescribed for a diagnosis of primary progressive multiple sclerosis or a non-relapsing form of secondary progressive multiple sclerosis, continues to benefit from the prescribed Multiple Sclerosis Agent based on the prescriber's assessment

Q13. For Lemtrada (alemtuzumab), received the previous treatment course at least 12 months prior to the requested treatment course with Lemtrada (alemtuzumab).

Yes

No

Q14. For Mavenclad (cladribine), both of the following:

Has documentation of a recent lymphocyte count within recommended limits according to FDA-approved package labeling before initiating the second treatment course

Has not exceeded the recommended total number of treatment courses according to FDA-approved package labeling

Q15. For a non-preferred Multiple Sclerosis Agent with a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug.

Yes

No

Q16. Additional Information:



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Multiple Sclerosis Agents**

**Phone: 866-841-7659**

**Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Member Name:	Prescriber Name:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026-06