

Vumerity (diroximel fumarate) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

| MEMBER'S LAST NAME: | | _ MEMBER'S FIRST N | MEMBER'S FIRST NAME: | | |
|---|--------------------------------|-------------------------------|---|--|--|
| | ., chart notes or lab data, to | | any additional documentation that is ion request). Information contained in | | |
| | | | ☐ URGENT | | |
| MEMBER INFORMATION | | | | | |
| LAST NAME: | | FIRST NAME: | | | |
| PHONE NUMBER: | | DATE OF BIRTH: | DATE OF BIRTH: | | |
| STREET ADDRESS: | | - | | | |
| CITY: | _ | STATE: Z | IP CODE: | | |
| PATIENT INSURANCE ID NU | MBER: | | | | |
| ☐ MALE ☐ FEMALE HEI | | | | | |
| IF YOU ARE NOT THE PATIENT OR THE PRESCR FOLLOWING LINK: HTTPS://MAGELLANRX.CO | | | VITH THIS REQUEST WHICH CAN BE FOUND AT THE SURE AUTHORIZATION.PDF | | |
| PATIENT'S AUTHORIZEDREPI AUTHORIZED REPRESENTATI | | | | | |
| PRESCRIBER INFORMATION | | | | | |
| LAST NAME: | | FIRST NAME: | | | |
| PRESCRIBER SPECIALTY: | | EMAIL ADDRESS: | EMAIL ADDRESS: | | |
| NPI NUMBER: | | DEA NUMBER: | DEA NUMBER: | | |
| PHONE NUMBER: | | FAX NUMBER: | FAX NUMBER: | | |
| STREET ADDRESS: | | | | | |
| CITY: | | STATE: Z | STATE: ZIP CODE: | | |
| REQUESTOR (if different than prescriber): | | OFFICE CONTACT P | OFFICE CONTACT PERSON: | | |
| | | - | | | |
| MEDICATION OR MEDICAL | DISPENSING INFORMATION |)N | | | |
| MEDICATION NAME: | | | | | |
| DOSE/STRENGTH: | FREQUENCY: | LENGTH OF THERAPY/REFILLS: | QUANTITY: | | |
| ☐ NEW THERAPY | RENEWAL | IF RENEWAL: DATE | THERAPY INITIATED: | | |
| DURATION OF THERAPY (SPI | ECIFIC DATES): | | | | |

Continued on next page.



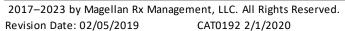


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|---|--|--|
| | | |
| 1. HAS THE PATIENT TRIED ANY OTHE | R MEDICATIONS FOR THIS CONDITION? | YES (if yes, complete below) NO |
| MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): | DURATION OF THERAPY (SPECIFY DATES): | RESPONSE/REASON FOR FAILURE/ALLERGY: |
| 2. LIST DIAGNOSES: | | ICD-10: |
| □ Clinically Isolated Syndrome(CIS) □ Relapsing remitting multiple sclerosis □ Secondary Progressive multiple sclero | sis | |
| □ Other diagnosis: | ICD-10 Code(s): | |
| 3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION. | N: PLEASE PROVIDE ALL RELEVANT CLIN | ICAL INFORMATION TO SUPPORT A |
| Clinical Information: Is drug going to be used in conjuncti Initial Request: Is the prescriber a neurologist? Has patient had a 3 month trial each dimethyl fumarate fingolimod glatiramer acetate teriflunomide | | No Please provide documentation. |
| | <u> </u> | of disease maintained with continued |
| Are there any other comments, diagn physician feels is important to this re | oses, symptoms, medications tried or faview? | iled, and/or any other information the |
| Please note: Not all drugs/diagnosis a information is received. | re covered on all plans. This request may | y be denied unless all required |



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|--|----------------------|--|--|
| ATTESTATION: I attest the information provided is true a the Health Plan, insurer, Medical Group or its designees n information necessary to verify the accuracy of the inform | • • | | |
| Prescriber Signature or Electronic I.D. Verification: | Date: | | |
| CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in re liance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents. | | | |

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811

Magellan Rx MANAGEMENTS