

Mayzent (siponimod) Prior Authorization Request Form



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

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

MEMBER INFORMATION				
LAST NAME:	FIRST NAME:			
PHONE NUMBER:	DATE OF BIRTH:			
STREET ADDRESS:				
CITY:	STATE: ZIP CODE:			
PATIENT INSURANCE ID NUMBER:				
MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES:				

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: <u>https://magellanrx.com/member/external/commercial/common/doc/en-us/phi_disclosure_authorization.pdf</u>

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): ______

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION			
LAST NAME:	FIRST NAME:		
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:		
NPI NUMBER:	DEA NUMBER:		
PHONE NUMBER:	FAX NUMBER:		
STREET ADDRESS:			
CITY:	STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:		

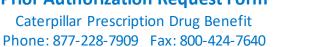
MEDICATION OR MEDICAL DISPENSING INFORMATION					
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:		
DURATION OF THERAPY	RENEWAL ECIFIC DATES):	IF RENEWAL: DATE THERAPY INITIATED:			

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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHEI	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 				
🗆 Other diagnosis:	ICD-10:			
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.				
Clinical Information:				
Wil patient use drug in conjuntion wi	ith a clinical trial? 🗆 Yes 🗆 No			
Is the prescriber a neurologist?				
Has patient had a 3 month trial each of at least 2 of the following? Yes No Please provide documentation. dimethyl fumarate fingolimod glatiramer acetate teriflunomide <u>Renewal Request:</u> Is prescriber a neurologist? Yes No				
Is patient continuing to demonstrate a positive response to therapy? Yes No Please submit chart documentation.				
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?				
*Please note: Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.				
ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.				
Prescriber Signature or Electronic I.D.	Verification:	Date:		
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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

