Gilenya
(fingolimod)
Prior Authorization Form

Express Scripts
Phone 800-417-8164
1) Fax 877-837-

Last Name	First Name	Prescriber's Name	Specialty
Home Phone	Work Phone	Office Phone	Office Fax
Home Address City State ZIP		Address City State ZIP	
SCAN ID number	Date of Birth	Est. Start Date	Office Contact
For Specialty Medications Only: Shipping Address (if different from home address) ☐ Physician ☐ Home		Special Instructions (i.e. Non-English Speaking Patient, etc.)	

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number

1. **Is the diagnosis or indication for the treatment of patients with relapsing forms of Multiple Sclerosis to reduce the frequency of clinical exacerbations and to delay the accumulation of physical disability?**

   ☐ **Yes** ☐ **No**
   If no, continue to #7

2. **Is Gilenya being prescribed by a Neurologist?**

   ☐ **Yes** ☐ **No**
   If no, continue to #7

3. **Has the patient used Betaseron or Copaxone prior to the use of Gilenya?**

   ☐ **Yes** ☐ **No**
   If no, continue to #7

4. **Is the patient at higher risk for bradyarrhythmia (e.g., the patients receiving Class Ia or Class III antiarrhythmic drugs, beta blockers, calcium channel blockers, those with a low heart rate, history of syncope, sick sinus syndrome, 2nd degree or higher conduction block, ischemic heart disease, or congestive heart failure etc.)?**

   ☐ **Yes** ☐ **No**
   If no, continue to #6

5. **Is the following test being performed prior to initiation Gilenya: baseline ECG?**

   ☐ **Yes** ☐ **No**
   If no, continue to #7

6. **Are the following tests being performed prior to initiation of Gilenya:**

   ☐ **A recent CBC (i.e., within the last 6 months)**
   ☐ **A recent (i.e., within the last 6 months) liver enzymes: transaminase and bilirubin levels**
   ☐ **An ophthalmologic evaluation**

   ☐ **Yes** ☐ **No**

7. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Physician's Signature: ____NPI/DEA #: ______________________ Date: ________________

1) For Internal Use Only

☐ Approved ☐ Denied Reviewer's Initials ___________________ Decision Date ____________________

Comments____

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.scanhealthplan.com.