US Family Health Plan
Prior Authorization Request Form for
fingolimod **(Gilenya)**

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) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a documented diagnosis for a relapsing form of multiple sclerosis (MS)?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. Will Gilenya be used with a disease-modifying therapy (for example, Aubagio, Avonex, Betaseron, Copaxone, Extavia, Rebif, Tecfidera, Tysabri)?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 3
3. Does the patient have a recent history within the last 6 months of: class III or class IV heart failure, myocardial infarction, unstable angina, stroke, transient ischemic attack [TIA], or decompensated heart failure requiring hospitalization?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 4
4. Does the patient have a history or presence of Mobitz type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless they have a functioning pacemaker?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 5
5. Does the patient have a baseline QTc interval of 500 milliseconds (msec) or greater?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 6
6. Is the patient receiving treatment with a class Ia or class III antiarrhythmic drug (for example, disopyramide [Norpace], quinidine, procainamide, amiodarone, dofetilide [Tikosyn], dronedarone [Multaq], sotalol [Betapace]?	☐ Yes **STOP** Coverage not approved	☐ No Sign and date below

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[04 March 2015]