US Family Health Plan
Prior Authorization Request Form for
cladribine **(Mavenclad)**

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 855-273-5735

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. Is the requested medication being prescribed by or in consultation with a neurologist?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a documented diagnosis of relapsing-remitting multiple sclerosis, or active secondary progressive multiple sclerosis?	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Will Mavenclad be used in conjunction with another disease-modifying therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **4**
4. Has the patient failed another disease-modifying therapy?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have current malignancy?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **6**
6. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **7**
7. Does the patient (male or female) have reproductive potential?	☐ Yes proceed to question **8**	☐ No proceed to question **9**

Continue on next page

8. Does the patient (male or female) plan to use effective contraception during treatment and 6 months after the last dose?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have an active chronic infection (for example, hepatitis, tuberculosis, or HIV infection)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**
10. Will hematological and lymphocytic parameters be monitored before, during, and after treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

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

Prescriber Signature _____ Date _____

[19 June 2019]