Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Prior Authorization (PA) Form

Multiple Sclerosis Clinical Edit for Mavenclad™ or Mayzent™

If the following information is not complete, correct, or legible, the PA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: __ __ – __ __ – __ __ __ __

Gender: ☐ Male ☐ Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

AVAPEC-2305-19 December 2019

Multiple Sclerosis Clinical Edit for Mavenclad ™ or Mayzent™

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

1. Is the member at least 18 years of age? ☐ Yes ☐ No

2. Member has a baseline MRI before initiating the first treatment course (within 3 months prior to start of therapy) ☐ Yes ☐ No

3. Indicate all that apply below

☐ Relapsing-remitting disease [RRMS] ☐ Secondary progressive disease [SPMS] with relapses

☐ Clinically isolated syndrome (CIS) ☐ Member has had ≥ 1 relapse within the previous 2 years

☐ Member has new and unequivocally enlarging T2 contrast enhancing lesions as evidenced by MRI and has had ≥1 relapse in the previous 12 months. ☐ Other _____

4. Has the member had a treatment failure, or contraindication to other agents used to treat MS

☐ Yes ☐ No List previous medications (include drug name/dose): _____

5. Mavenclad™ OR Mayzent™ will be used as single agent therapy ☐ Yes ☐ No

6. Member has been tested for antibodies to the varicella zoster virus (VZV) or has received immunization for VZV 4 weeks prior to beginning therapy. ☐ Yes ☐ No

7. Member should be screened for the presence of tuberculosis according to local guidelines ☐ Yes ☐ No

8. Member has been evaluated and screened for the presence of hepatitis B and hepatitis C virus (HBV/HCV) prior to initiating treatment; Active infection, including clinically important localized infections. ☐ Yes ☐ No

9. **<u>Mavenclad™ SPECIFIC</u>**

   a) Lymphocyte count is ≥ 800 cells/mL prior to start of therapy ☐ Yes ☐ No

   b) Women of child bearing age must have a negative pregnancy test prior to treatment; AND Members of reproductive potential must use effective contraception during treatment with therapy and for at least 6 months after the last dose
   ☐ Yes ☐ No

   c) Member does not have human immunodeficiency virus (HIV) infection ☐ Yes ☐ No

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

10. Mayzent™ SPECIFIC

a) Member has been tested for CYP2C9 variant status to determine genotyping (required for dosing) ☐ Yes ☐ No

b) Member has obtained a baseline electrocardiogram (ECG) ☐ Yes ☐ No

c) Member has had a baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment ☐ Yes ☐ No

11. Member on **Mayzent™ does NOT** have any of the following:

☐ Recent myocardial infarction ☐ unstable angina ☐ stroke

☐ transient ischemic attack, ☐ decompensated heart failure with hospitalization,

☐ Class III/IV heart failure within the previous 6 months;

☐ Prolonged QTc interval at baseline (>500 msec); ☐ CYP2C9*3/*3 genotype

☐ History of Mobitz Type II second or third-degree atrioventricular block or sick sinus syndrome (unless treated with a functioning pacemaker)

12. Mayzent™ **W**ill NOT be used in combination with the following:

a. Moderate or strong CYP3A4 inducers (e.g., modafinil, efavirenz, etc.) in members with a CYP2C9*1/*3 and CYP2C9*2/*3 genotypes; OR
b. Drug regimens that contain CYP2C9/CY3A4 dual inhibitors (e.g., fluconazole) ; OR
c. Moderate CYP2C9 inhibitor plus a moderate-to-strong CYP3A4 inhibitor;
d. Other antineoplastic, immunosuppressive or immunomodulating drugs

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.

The completed form may be: **FAXED TO 1-844-512-7020.**