



Gilenya Prior Authorization

**Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients who are prescribed Gilenya must follow these guidelines:

- *Note:**
- **Must have relapsing forms of multiple sclerosis.**
 - **Must have a current electrocardiogram (within 6 months) for patients taking anti-arrhythmics, beta-blockers, or calcium channel blockers; patients with cardiac risk factors; and patients with a slow or irregular heart beat.**
 - **Must have a recent CBC (within 6 months).**
 - **Must have an adequate ophthalmologic evaluation at baseline and 3-4 months after treatment initiation.**
 - **Must have recent (within 6 months) transaminase and bilirubin levels before initiation of therapy.**
 - **Will not be approved for use in combination therapy**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Physician Name					
Physician Medicaid Provider Number			Telephone Number		Fax Number
Address		City		State	Zip Code
Requested Drug and Dosage: <input type="checkbox"/> Gilenya			Diagnosis for this request:		
Qualifications for coverage:					
Current electrocardiogram	Current CBC	Ophthalmologic Evaluation		Transaminase/Bilirubin levels	
Date:	Date:	Date:		Date:	
Physician Signature				Date	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
PHONE NUMBER	FAX NUMBER	DRUG		NDC #	

Part III: FOR OFFICIAL USE ONLY

Date Received				Initials:	
Approved - Effective dates of PA:	From:	/	/	To:	/ /
Denied: (Reasons)				Approved by:	