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

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: **Male** **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's 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.)

 Revised: 10/12/2021 | Effective: 01/01/2022

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. Has the member had a baseline magnetic resonance imaging (MRI) before initiating the first treatment course (within 3 months prior to start of therapy)?

   Yes No

3. Indicate all that apply:

   Relapsing-remitting disease (RRMS)

   Secondary progressive disease (SPMS) with relapses

   Clinically isolated syndrome (CIS)

   Member has had ≥ 1 relapse within the previous two 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 multiple sclerosis (MS)? List previous medications (include drug name/dose):

   Yes No

   Previous medication(s): _____

5. Will Mavenclad®, Mayzent®, Ponvory™, Zeposia® be used as single-agent therapy?

   Yes No

6. Has the member been tested for antibodies to the varicella zoster virus (VZV) or received immunization for VZV four weeks prior to beginning therapy?

   Yes No

7. Has the member been screened for the presence of tuberculosis according to local guidelines?

   Yes No

8. Has the member been evaluated and screened for the presence of hepatitis B and hepatitis C virus (HBV/HCV) prior to initiating treatment?

   Yes No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

9. **Mavenclad® specific**

   a. Is the lymphocyte count ≥ 800 cells/mL prior to start of therapy?

      Yes No

   b. Please attest that women of child bearing age are not pregnant **and** that members of reproductive potential must use effective contraception during treatment with therapy and for at least six months after the last dose.

      Yes No

   c. Does the member have human immunodeficiency virus (HIV) infection?

      Yes No

10. **Mayzent® Specific**

   a. Has the member been tested for CYP2C9 variant status to determine genotyping (required for dosing)?

      Yes No

11. **Mayzent®, Ponvory™ or Zeposia® specific**

   a. Please attest that women of child bearing age are not pregnant and that members of reproductive potential must use effective contraception during treatment.

      Yes No

   b. Has the member obtained a baseline electrocardiogram (ECG)?

      Yes No

   c. Has the member had a baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment?

      Yes No

12. Before using **Mayzent®, Ponvory™ or Zeposia®**, can you attest that the member 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 (**Mayzent® only)**
   - History of Mobitz Type II second or third-degree atrioventricular block or sick sinus syndrome (unless treated with a functioning pacemaker)

      Yes No

(Form continued on next page.)

13. Can you confirm that **Mayzent®** will **not** be used in combination with the following?:

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

Yes No

14. Can you confirm **Zeposia®**will **not** be used in combination with the following?:

- Will **not** be initiating therapy after previous treatment with alemtuzumab; **OR**
- Monoamine oxidase inhibitor (MAOI) (e.g., selegiline, phenelzine, linezolid); **OR**
- Drugs known to prolong the QT-interval (e.g., fluoroquinolone or macrolide antibiotics, venlafaxine, fluoxetine, quetiapine, ziprasidone, sumatriptan, zolmitriptan); **OR**
- Strong cytochrome p450 2C8 (CYP2C8) inhibitors (e.g., gemfibrozil) or inducers (e.g., rifampin); **OR**
- BCRP inhibitors (e.g., cyclosporine, eltrombopag); **OR**
- Adrenergic or serotonergic drugs which can increase norepinephrine or serotonin (e.g., opioids, selective serotonin reuptake inhibitors [SSRIs], selective norepinephrine reuptake inhibitors [SNRIs], tricyclics, tyramine); **OR**
- Foods with large amounts of tyramine (e.g., > 150 mg), such as aged cheeses, cured meats, craft/unfiltered beers, beans); **OR**
- Other antineoplastic, immunosuppressive or immunomodulating drugs (**Note**: if there is a history of prior use of these drugs, consider possible unintended additive immunosuppressive effects); **AND**
- Patient will **not** receive live vaccines during and at least 4 weeks prior to and 12 weeks after treatment; **AND**
- Patient does **not** have an active infection, including clinically important localized infections

Yes No

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 SA process.
Submission of documentation does NOT guarantee coverage by Molina Complete Care.

The completed form may be **FAXED to 1-844-278-5731**, or you may call the number below.

CCC Plus: 1-800-424-4524 (TTY 711)
Medallion 4.0: 1-800-424-4518 (TTY 711)

www.MCCofVA.com

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