Gilenya® (fingolimod) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: ______________________ Phone: ____________ Fax: ____________

A. PATIENT INFORMATION

First Name: | Last Name:
Address: | City: | State: | ZIP:
Home Phone: | Work Phone | Cell Phone:
DOB: | Allergies: | Email:
Current Weight: ________ lbs or ________ kgs Height: ________ inches or ________ cms

B. INSURANCE INFORMATION

Aetna Member ID #: ____________________
Group #: ____________________
Insured: ____________________

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ____________ Carrier Name: ____________
Insured: ____________________

Medicare: ☐ Yes ☐ No If yes, provide ID #: ____________ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: ____________

C. PRESCRIBER INFORMATION

First Name: | Last Name: | *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.
Address: | City: | State: | ZIP:
Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN:
Provider Email: | Office Contact Name: | Phone:

Specialty *(Check one)*: ☐ **Neurologist** ☐ **Primary Care** ☐ **Other**: ____________________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ____________
Center Name: ____________
☐ Home Infusion Center Phone: ____________
Agency Name: ____________
☐ Administration code(s) (CPT): ____________
Address: ____________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: ____________
Name: ____________
Phone: ____________ Fax: ____________
Address: ____________
TIN: ____________ PIN: ____________

E. PRODUCT INFORMATION

Request is for Gilenya: Dose: ____________ **Frequency:** ____________

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: ____________ Secondary ICD Code: ____________ Other ICD Code: ____________

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For *All* Requests:

Please indicate the type of multiple sclerosis the patient has been diagnosed with:

☐ Relapsing -remitting MS ☐ Secondary- progressive MS ☐ Primary- progressive MS ☐ Progressive- relapsing MS

☐ Yes ☐ No Has the patient discontinued other medications used for treating MS (not including Ampyra)?
☐ Yes ☐ No Will the patient have an ECG prior to the first dose and at the end of the observation period?

For *Initiation* Requests:

☐ Yes ☐ No Does the patient have a documented recent (within 6 months) complete blood count (CBC)?
→ Please indicate the date of the CBC testing: Date: ____/____/____
☐ Yes ☐ No Does the patient have a documented recent (within 6 months) liver transaminase and bilirubin?
→ Please indicate the results and date of the lab work:
ALT: ______ IU/mL Date: ____/____/____
AST: ______ IU/mL Date: ____/____/____
Bilirubin: ______ mg/dL Date: ____/____/____

☐ Yes ☐ No Has the patient had a recent (within the last 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure?
☐ Yes ☐ No Does the patient have history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome?
☐ Yes ☐ No Does the patient have a pacemaker?
☐ Yes ☐ No Does the patient have a baseline QTc interval ≥500 ms (as measured on most recent ECG)?
☐ Yes ☐ No Is the patient on any Class Ia or Class III anti-arrhythmic drugs?
☐ Yes ☐ No Does the patient have a documented baseline ophthalmologic examination? ***If yes***, date of the eye exam: Date: ____/____/____
☐ Yes ☐ No Does the patient have a documented history of chicken pox or administration of the varicella zoster vaccine (VZV)?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For *Restart* Requests:

Please enter the date treatment was stopped**:** Date: _____/_____/_____

☐ Yes ☐ No Will the patient have an ECG prior to first re-initiated dose and at the end of the observation period?

For *Continuation* Requests:

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Gilenya? (Sampling of Gilenya does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: ____ **Date:** _____/_____/_____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.