

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

**GILENYA (fingolimod)**

Patient name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber NPI#: \_\_\_\_\_ Contact person: \_\_\_\_\_

Prescriber Phone#: \_\_\_\_\_ Extension/Option: \_\_\_\_\_ Fax#: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

Requested Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency/Day: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED  
FORM TO 855-828-4992 note the new fax number**

**CRITERIA:**

- Minimum age requirement: 18 years old.
- Documented diagnosis of relapsing-remitting Multiple Sclerosis.
- Dose limited to less than or equal to 0.5mg once daily.
- A written plan to monitor for bradyarrhythmia in-office or clinic for six hours following the first dose.
- Baseline test values (within the preceding six months) within normal limits:
  - Complete Blood Count (CBC)
    - WBC between  $3.2 \times 10^3$  and  $9.8 \times 10^3$  cells/mm<sup>3</sup>
    - Hgb between 12 and 18 g/dL
    - Hct between 33 and 49%
    - Platelets between  $140 \times 10^3$  and  $440 \times 10^3$  cells/microL
  - Liver Function Tests (LFT)
    - AST and/or ALT between 0 and 35 IU/L
  - Electrocardiogram (ECG) within normal limits
  - Ophthalmic exam within normal limits

**AUTHORIZATION:**

Initial authorization will be granted for three months. If baseline CBC, LFT, ECG, and/or ophthalmic exam results are not within normal limits, compelling rationale for initiation of therapy must be provided in a detailed letter of medical necessity.

**RE-AUTHORIZATION:**

Re-authorization requires updated CBC, LFT, ECG, and ophthalmic exam. Reauthorization will be granted if values for CBC, LFT, ECG, and ophthalmic exam remain within normal limits. If updated CBC, LFT, ECG, and/or ophthalmic exam results are not within normal limits, compelling rationale for continuation of therapy must be provided in a detailed letter of medical necessity. Reauthorization will be granted in one-year increments.

09/28/2011

<http://health.utah.gov/medicaid/pharmacy>